Addressing the links between gender-based violence and HIV in the Great Lakes region.

Country report: Kenya
Mary Amuyunzu-Nyamongo, PhD
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Mary Amuyunzu-Nyamongo, PhD

\[1\] Ms. Amuyunzu-Nyamongo is a Kenyan anthropologist and gender specialist and the Executive Director of the African Institute for Health and Development based in Nairobi.
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<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immuno-Deficiency Syndrome</td>
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<td>AMWIK</td>
<td>Association of Media Women in Kenya</td>
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<td>ART</td>
<td>Anti-retroviral therapy</td>
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<td>AWC</td>
<td>Africa Women and Child Feature Services</td>
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<td>BBC</td>
<td>British Broadcasting Corporation</td>
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<td>BHESP</td>
<td>Bar Hostesses Empowerment and Support Programme</td>
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<td>CREAT</td>
<td>Centre for Rights and Education Awareness</td>
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<td>CSIS</td>
<td>Centre for Strategic and International Studies</td>
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<td>FGM</td>
<td>Female genital mutilation</td>
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<td>FIDA</td>
<td>Federation of female lawyers</td>
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<td>GBV</td>
<td>Gender-based violence</td>
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<td>GVI</td>
<td>Gender-based violence information system</td>
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<td>GOK</td>
<td>Government of Kenya</td>
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<td>GVRC</td>
<td>Gender violence rescue centre</td>
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<td>HIV</td>
<td>Human immune-deficiency virus</td>
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<td>HOYMAS</td>
<td>Health Options for Young Men on HIV/AIDS/STIs</td>
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<td>IDPs</td>
<td>Internally displaced persons</td>
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<tr>
<td>IDU</td>
<td>Injectable drug use</td>
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<td>IRIN</td>
<td>Integrated Regional Information network</td>
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<td>KDHS</td>
<td>Kenya Demographic and Health Survey</td>
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<td>KEWOPA</td>
<td>Kenya Women Parliamentary Association</td>
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<td>KNASP</td>
<td>Kenya National HIV and AIDS Strategic Plan</td>
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<td>LVCT</td>
<td>Liverpool Voluntary Counselling and Testing</td>
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<td>MARPS</td>
<td>Most at risk populations</td>
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<td>MEGEN</td>
<td>Men for Gender Equality Now</td>
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<td>MenKen</td>
<td>Men Engage Kenya Network</td>
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<td>MMAK</td>
<td>Movement of Men against AIDS in Kenya</td>
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<td>MSM</td>
<td>Men who have sex with men</td>
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<td>NACC</td>
<td>National AIDS Control Council</td>
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<td>NEPHAK</td>
<td>Network Empowerment of People with HIV/AIDS in Kenya</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>NGEC</td>
<td>National Gender and Equality Commission</td>
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<td>NGOs</td>
<td>Non-governmental organizations</td>
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<td>OST</td>
<td>Opioid substitution therapy</td>
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<td>OVC</td>
<td>Orphans and vulnerable children</td>
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<td>PAHO</td>
<td>Pan-African Health Organization</td>
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<td>PEP</td>
<td>Post Exposure Prophylaxis</td>
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<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
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<td>PLHIV</td>
<td>People living with HIV</td>
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<td>PMTCT</td>
<td>Prevention of mother to child transmission</td>
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<td>SOWED</td>
<td>Social Welfare and Development</td>
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<tr>
<td>STI</td>
<td>Sexually transmitted infections</td>
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<td>SWOP</td>
<td>Sex Workers Outreach Programme</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV and AIDS</td>
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<td>UNFPA</td>
<td>United Nations Fund for Population Activities</td>
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<td>UNGASS</td>
<td>United National General Assembly</td>
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<td>UNHCR</td>
<td>United Nations High Commission for Refugees</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<td>WOFAK</td>
<td>Women fighting AIDS in Kenya</td>
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EXECUTIVE SUMMARY

Background: Gender-based violence (GBV) and HIV/AIDS are both significant health and human rights concerns, globally and more so in developing countries. These epidemics overlap and intersect in complex ways, which have not yet been fully mapped or understood. Evidence shows that living with HIV may constitute a risk factor for experiencing GBV with an increase in violence following disclosure of HIV status or even following disclosure that HIV testing has been sought. Although there is research on the links between GBV and HIV/AIDS, important gaps persist with regard to the conceptualization of the links between the two and the interventions and policies designed to address them.

Objective: This study was designed to review recent findings on the relationship between GBV and HIV/AIDS. The results would inform current knowledge of the aspects of HIV/AIDS and GBV in Kenya that require further study. To carry out the study, multiple approaches were used: desk reviews of published and unpublished literature; analysis of Kenya Demographic and Health Survey data (2008/9); and in-depth interviews with 22 representatives of institutions based in Nairobi that work on HIV/AIDS and/or GBV.

HIV/AIDS: The assessment indicates that the awareness on HIV/AIDS has increased over time coupled with an increased access to counselling, testing and treatment. The concerted efforts of the Kenya government and its development partners have seen 73.5% of females and 58.6% of males reporting having tested for HIV by 2009. In addition, treatment coverage was reported at 61% of those who needed to be on treatment. Prevention of mother-to-child transmission (PMTCT) has expanded to most parts of the country. However, there are challenges due to the increasing risk of HIV transmission among the most at risk populations (MARPS) including injecting drug users (IDUs), homosexuals and sex workers. Stigma continues to be a problem especially among women who often risk GBV upon disclosure, among other negative impacts. It is notable that funding for HIV/AIDS activities has been reducing due to efficiency concerns by the donors. Although the government has promised an increased budgetary allocation, about 85% of programme funding is by donor partners.

Gender-based violence: This is rooted in unequal power relations in society. Studies show that most cases of GBV take place in families, communities and institutions including schools, detention centres and religious facilities. The KDHS (2008/9) reported that 39% of women aged 15-49 years had ever been physically or sexually assaulted by their husbands or intimate partners during their lifetime. About 21% of the women aged 15-49 years reported having ever been sexually violated while 12% of the respondents reported that their first sexual intercourse was forced. The KDHS included a module on women’s behaviour that justifies physical abuse by the spouse or intimate partner. Although there were no differences between the men and women (pointing to normalization of violence), there were differences on opinion based on the education attainment of the respondents: those with no education and those who had attained primary level education were more inclined to confirm that a beating was warranted; and socio-economic status: those classified as the poorest and poor indicating that a woman’s misbehaviour warranted physical punishment.
Conflicts: Kenya experiences regional conflicts that are mainly resource-based and politically instigated. For instance, the country has systematically experienced political-related conflict since 1992 (every 5 years during national elections), the most significant having occurred during and following the 2007 disputed presidential elections. During the post-election violence period an average of 260 survivors were attended to per month for the period January to March 2008. The majority were women and children, who ranged in age from 1 month to 105 years. This indicates a failure in the implementation of the Sexual Offences Act (2006) and other legislation including the Children’s Act (2001). The IDIs conducted as part of this study identified the following as key factors in conflict in relation to HIV/AIDS and GBV: historical injustices that have resulted in some parts of the country being poorer than others; land and resource scarcity and inequitable access to the same; the men left behind to protect the women during conflict, including armed officers, often take advantage of them (as was the case in the Tana Delta clashes of 2012); politicization of the masses for individual political benefit; normalization of violence and conflict in the homes mainly through the influence of the media; and the ease availability of small arms as a result of conflict in neighbouring countries.

Legislation: Kenya has several pieces of legislation of relevance to both HIV/AIDS and GBV including: the Constitution of Kenya 2010, which has provisions on protection of women, children and other marginalized groups; the HIV/AIDS Prevention and Control Act (2006); Children’s Act (2001), Sexual Offences Act (2006), Female Genital Mutilation (FGM) Bill (2010); and Marriage Bill (2012). Draft bills include the Matrimonial Property Bill (2009), the Equal Opportunities Bill (2007), and the Family Protection Bill (2007). The implementation of the provisions of relevance to HIV/AIDS and GBV however remains weak. Although Kenya is a signatory to most international declarations, the operationalization of these also remains weak. Furthermore, even though there are gender desks in ministry offices and police stations, they were found by the research team to be ineffective due to bureaucratic challenges and lack of capacity among the officers.

Linkages between HIV and GBV: Linking GBV and HIV/AIDS efforts is both a necessary and a potentially powerful strategy for addressing the structural drivers of each and achieving lasting results in the fight against both epidemics. Both require a comprehensive response: one that simultaneously addresses the biomedical, behavioural, and social risk factors and implications for the affected populations. Both require well-coordinated, multi-sectoral efforts that tackle the multiple dimensions through which violence and HIV infection affect people’s lives, including their health, education, social interactions, economic opportunities, safety and human rights. And both must be addressed as a continuum throughout the lifecycle of individuals to ensure lasting results.

The KDHS (2008/9) included the collection of biomarkers for HIV testing and a module on GBV but the questions on GBV were not matched to the HIV testing. An attempt to link the results from the two modules was undertaken by the research team to assess whether a pattern would emerge linking GBV and HIV. The analysis points to a close link between sexual violence and HIV prevalence across the country while physical and emotional violence do not seem to be closely linked to HIV infection.
Conclusion: The linkage between HIV infections to GBV is mainly through sexual relations, influenced by socio-cultural factors including gender power imbalance. It is evident that factors such as sexual abuse, the unfavourable economic position of women, and the inability of women to successfully negotiate condom use make Kenyan women unable to determine the conditions under which sex occurs. Thus, they are rendered powerless to protect themselves against HIV infection. In order to break the silence on HIV/AIDS and GBV, the government needs to mainstream gender and children’s rights programmes, as well as engage boys and men in the prevention of and response to GBV. Although non-governmental organizations (NGOs) have played and continue to play a key role in addressing HIV/AIDS and GBV, their efforts are limited in scope and time.

Recommendations: The recommendations are presented in three parts: policy; programmatic; and research.

Policy recommendations
i. Align the existing legislation with the Constitution of Kenya 2010 to ensure coherence with the current context using a language that also addresses boys and men.
ii. Ensure the implementation of the various legislation on GBV and HIV/AIDS at the national and county levels.
iii. Monitor the implementation of international and national commitments on GBV and HIV/AIDS at the national and county levels.

Programmatic recommendations
i. Address the social, economic and legal gender inequalities in the country in line with the Bill of Rights as provided for the Constitution of Kenya 2010. This would require a strategic and holistic approach that safeguards the lives of Kenyans with effective early warning systems.
ii. Strengthen judicial processes and enforce deterrent sentences while more visible prosecution of perpetrators is carried out. Utilize community level structures, such as the council of elders, youth, women and religious groups to coordinate with the legal structures to sensitize communities on the superiority of the law and how to utilize it.
iii. Utilize existing HIV/AIDS infrastructure (such as VCT centres) and GBV interventions (such as the Nairobi Women’s Hospital and Kenyatta National Hospital Gender Based Violence Recovery Centres) to drive the joint HIV/AIDS and GBV agenda.
iv. Strengthen the National Gender Equality Commission (NGEC) through provision of a gender-sensitive budget to guide, monitor and evaluate joint HIV/AIDS and GBV programming. Performance contracting should include gender mainstreaming, which would require outputs and outcomes from the NGEC.
v. Expand the scope of gender programming in all sectors to include boys and men and ensure that the officers responsible for gender are trained to handle men who are abused by their intimate partners.

vi. Sensitize aid workers and enforcement officers on managing conflict situations. Measures should be put in place to hold them accountable for their actions.

vii. Establish an investigative unit within the National Council for People with Disability to assess and document cases of abuse especially in institutions that should be protecting those with disabilities.

Research recommendations

i. Given the importance of gender as a determinant of both GBV and HIV/AIDS, it is critical that further research be conducted in Kenya to assess and confirm the causal linkages between the two epidemics. Data should be disaggregated based on gender, physical ability/inability, age and sexual orientation to inform targeted programming and policy reforms.

ii. Assess the feasibility of joint actions including budgeting on both HIV/AIDS and GBV.

iii. The effectiveness of early warning on conflict should be assessed through the implementation of action research.

iv. Investigate and document the experiences of both HIVAIDS and GBV among men and women during conflict. For example, those in camps and returnees – soldiers and community members.

v. Investigate and document the experiences of both HIVAIDS and GBV among men and women during conflict to provide the evidence base for programming.

vi. Assess the role of media in GBV and the appropriate measures for transformative gender reporting.

1.0 INTRODUCTION

1.1 Background

Gender-based violence (GBV) and HIV/AIDS are both significant health and human rights concerns. The two epidemics overlap and intersect in complex ways, which have not yet been fully mapped or understood. A thorough understanding of these intersections is however vital for planning adequate policy responses to GBV and HIV. For instance, in 2010 sub-Saharan Africa accounted for 70% of new HIV infections globally (UNAIDS, 2011). Girls and women represent 59% of those living with HIV in the region and continue to be more vulnerable to new infections due to social, political, cultural and economic gender inequalities. Evidence shows that among young women, gender inequality within a relationship increases the risk of infection by 13.9%.

Gender refers to the socially constructed roles, behaviour, activities and attributes that a particular society considers appropriate for men and women. The distinct roles and behaviour may give rise to gender inequalities, i.e. differences between men and women
that systematically favour one group. In turn, such inequalities can lead to inequities between men and women in their life experiences including their risk to diseases and other life events. It should be noted that in Kenya, ‘gender’ has generally been taken to connote ‘women’ instead of both ‘men’ and ‘women’.

Gender-based violence involving sexual violence is closely associated with HIV transmission, particularly in high-prevalence countries such as Kenya. Male perpetrators of violence may engage in behaviours with a high risk of HIV transmission, such as not using condoms and having sex with multiple partners. In addition, evidence from research suggests that GBV, or the fear of GBV, may interfere with the ability to negotiate safer sex, or to refuse unwanted sex. GBV may also interfere with the ability to access treatment and care, and the ability to maintain adherence to ARV treatment.

Empirical evidence shows that living with HIV/AIDS may constitute a risk factor for experiencing GBV, with an increase in violence following disclosure of HIV status, or even following disclosure that HIV testing has been sought (Amuyunzu-Nyamongo & Kiragu, 2005). Among women, the fear of experiencing violence may potentially delay an individual’s decision to disclose her HIV status and seek treatment when necessary and when most important for survival.

Conflict and emergency situations affect the intersections of GBV and HIV. Violence against women, particularly sexual violence, is widespread in conflict and post-conflict settings. In such situations, women and girls face increased risks of acquiring sexually transmitted infections (STIs) and HIV by: direct transmission through rape; being placed in situations where they may be forced to exchange sex for survival; and experiencing increased levels of overall violence including intimate partner violence, which in turn, makes it difficult for them to negotiate safe sex in their relationships. In addition, it may often be more difficult for girls and women in these situations to access adequate healthcare and treatment. Hence, the urgent need to identify, test and implement effective strategies for integrating programmes that address both GBV and HIV prevention and AIDS treatment and care in conflict settings.

Although there is research evidence on the links between GBV and HIV/AIDS, important gaps still remain both with regard to the conceptualization of the linkages between the two and the interventions and policies designed to address them. In particular the following areas remain under-researched:

i. Conflict and emergency conditions and post-conflict situations where rape and sexual violence are often reported to be high, and interventions to address the intersections between GBV and HIV/AIDS are lacking. Further investigation is needed around the potential causal or catalytic relationship between conflict settings and HIV/AIDS and GBV.

ii. The ‘perpetuating cycle’ between GBV and HIV/AIDS in terms of the two-way causal relationships that exist between the two epidemics.

iii. How gender is locally constructed and defined to enable a full understanding of how the epidemics are linked and can be jointly addressed. Research is needed to provide analysis of social constructions of gender and how these can exacerbate vulnerabilities to GBV and HIV/AIDS.
iv. Effective ways of engaging men as agents of change with regard to prevention of GBV and HIV/AIDS.

1.2 Objectives
This review was designed to assess HIV/AIDS epidemic and GBV in Kenya including a review of the latest sex disaggregated data that would conceptualize the relationships between the two. Key studies and academic articles that examine the connections between GBV and HIV/AIDS have been reviewed with the aim of clarifying what is known and yet to be known about the relationship of GBV to HIV/AIDS. The results are expected to inform policy and practice on HIV/AIDS and GBV in Kenya and identify areas for further study.

1.3 Approach
Multiple approaches were used to collect data including a desk review; analysis of Kenya Demographic and Health Survey (KDHS) dataset for 2008/9; and in-depth interviews (IDIs) with representatives of organizations working on GBV and HIV/AIDS based in Nairobi, Kenya. Following the drafting of the report, a validation meeting was held on June 04, 2013 involving five of the participants in the IDIs to review the report while a participant from the National AIDS Control Council (NACC) submitted her written comments. Their feedback has been incorporated in this report.

(i) Desk review
This process included a review of both published and unpublished documents. Materials with information on GBV and HIV/AIDS were gathered from institutions involved in the study. A review of the existing legislation was also done to inform the study.

(ii) Analysis of Kenya Demographic and Health Survey
The analysis focused on GBV and HIV/AIDS while assessing whether there is a linkage between the two. It should be noted that during the KDHS data collection the two variables were not linked, i.e., the people tested for HIV were not asked directly whether they had experienced any form of violence.

(iii) In-depth interviews
The study involved the conduct of 22 IDIs with representatives of institutions involved in GBV and HIV/AIDS – both national and regional organizations based in Nairobi, Kenya. The key issues addressed included their perceptions on HIV/AIDS and GBV; conflict and its impacts on HIV/AIDS and GBV; the linkages between HIV/AIDS and GBV; legislation on HIV/AIDS and GBV; level of programming; and suggestions on how to address the two issues jointly. The list of people met and the IDI guide utilized for data collection are provided in Annex 1 and 2, respectively.

(iv) Workshop
A validation was held June 04, 2013 with key stakeholders with the aim of discussing the draft report. The information gathered has been used to inform the finalization of the report. In addition, feedback received from UNESCO on the initial draft has been incorporated in the final revision.
2.0 SITUATIONAL ANALYSIS

2.1 HIV and AIDS in Kenya

A study conducted in 1985 reported HIV prevalence of 59% amongst a group of sex workers in Nairobi, which was the first group to be diagnosed with the virus. Towards the end of 1986 there was on average four new HIV cases being reported to the World Health Organization (WHO) each month. This totalled to 286 cases by the beginning of 1987, of which 38 had been fatal. By 1987 HIV appeared to be spreading rapidly among the population; an estimated 1-2% of adults in Nairobi were infected with the virus, and HIV prevalence among pregnant women in the capital had increased from 6.5% to a staggering 13% between 1989 and 1991. By 1994 an estimated 100,000 people had already died from AIDS and around 1 in 10 adults were infected with HIV. Based on these reports, the retired Kenyan President Daniel Arap Moi, in a speech at an AIDS awareness symposium in 1999, declared the AIDS epidemic a national disaster and announced that a National AIDS Control Council (NACC) would be established to tackle the scourge.

Studies indicate that HIV prevalence in Kenya began to gradually decline from its peak of 13.4% in 2000 to 6.9% in 2006 and to 6.3% in 2008/9 (KNBS & ICF Macro, 2010). The decrease in prevalence coincided with the rapid expansion of preventative interventions, which resulted in a change in sexual behaviour and the increased use of condoms. The decline was also attributed to the large number of people who were dying from AIDS in Kenya, which totalled to about 150,000 in 2003 alone (KNBS & ICF Macro, 2010).

Although HIV prevalence tends to differ according to location, gender and age, Kenya’s HIV epidemic has been generalized. Nearly half of all new infections in 2008 were transmitted during heterosexual sex whilst in a relationship and 20% during casual heterosexual sex (UNGASS, 2010). Various studies further reveal a high HIV prevalence amongst a number of key affected groups, including sex workers, injecting drug users (IDUs), homosexuals, truck drivers and cross-border mobile populations (UNGASS, 2008). It is however notable that some of these groups are marginalized within society. For example, homosexuality is illegal in Kenya and punishable by up to 14 years in prison. Therefore, these groups are difficult to reach with HIV prevention and AIDS treatment and care, and the extent to which HIV/AIDS is affecting these groups has not been fully explored. It is estimated that in 2008 about 3.8% new HIV infections were reported among IDUs generally while in Nairobi 5.8% of new infections were related to IDUs (St Rathdee et al., 2010). HIV infections are easily prevented in healthcare settings however 2.5% new HIV infections occurred in health facilities during 2008 in Kenya (UNGASS, 2010).

HIV disproportionally affects women: in 2008/09 HIV prevalence among women was twice as high as that for men at 8% and 4.3%, respectively. Adult HIV prevalence is greater in urban areas (8.4%) than rural areas (6.7%). However, an estimated 75% of people in Kenya live in rural areas, consequently the total number of people living with HIV is higher in rural (about 1 million adults) than urban settings (0.4 million adults) (UNGASS, 2010; KNBS & ICF Macro, 2010).

One of the 2010 targets set in Kenya’s National HIV and AIDS Strategic Plan 2005/06 - 2009/10 (KNASP II) was to test 2 million Kenyans for HIV annually. In order to reach this target, international development organizations and the Kenyan government introduced a number of new initiatives. One such programme, launched in late 2009, aimed to provide door-to-door HIV testing and counselling for those living in remote areas with little access to health care. This scheme raised concerns from Human Rights Watch, which urged the

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2This decline could also be due to the implementation of population based prevalence surveys instead of relying on sentinel surveillance based estimates.
Addressing the links between gender-based violence and HIV in the Great Lakes region.

government to ensure that principles of counselling, consent and confidentiality would be properly adhered to (Human Rights Watch, 2009).

The government’s enhanced focus on testing has been reflected in the proportion of adults aged 15-49 years who report to having ever been tested for HIV. In 2003 only 15% had taken a test compared to 37% in 2007 (UNGASS, 2008). Action to improve access to testing facilities and a high-profile media campaign that ran between 2002 and 2005 is suspected to have contributed to the increase in HIV testing uptake (Marum, et al., 2008). In the year 2010, it is estimated that more than 5.7 million Kenyans aged 15 years and over received HIV testing and counselling (WHO/UNAIDS/UNICEF, 2011). According to the 2008/2009 KDHS, 73.5% of women and 58.6% of men had been tested at least once (WHO/UNAIDS/UNICEF, 2010; KNBS & ICF Macro, 2010).

Although awareness of HIV and AIDS in Kenya is high, many people living with the virus still face stigma and discrimination. Studies have shown that although people are aware of the basic facts about HIV and AIDS, many are not informed of the more in-depth knowledge that addresses issues of stigma and discrimination (International Treatment Preparedness Coalition, 2007, December). For instance, only one-third of healthcare facilities that have policies to protect people living with HIV (PLHIV) against discrimination were actually implementing such policies (USAID, 2007). People are still afraid to disclose their status and will often avoid health centres that provide HIV services from fear of being seen by neighbours or community members (Human Rights Watch, 2008). Discussions with the interviewees involved in this study indicated that women tend to be the most affected since they tend to use health facilities more than the men. Furthermore, given the notion that people hide their status, being seen at a facility that offers HIV services could lead to speculation of secretly seeking the services.

HIV transmission through IDUs is a growing problem, particularly in Nairobi and in coastal areas. HIV prevalence among IDUs reached 21% in 2010 and in Nairobi around 1 in 3 IDUs are infected with HIV (WHO/UNAIDS/UNICEF, 2011). Even where IDUs in Kenya know how HIV is transmitted, needle sharing and unprotected sex are commonplace (Savanna, 2009; PlusNews, 2007). Up to 4% of all new infections are as a result of IDU (UNGASS, 2010).

The recognition by public health leaders that HIV infection risk among IDUs must be addressed through evidence-based approaches, including harm reduction services, is a promising step. However, many challenges remain. A 2011 report into HIV prevention among IDUs in Kenya found that there was a high prevalence of HIV in prisons, but no access to addiction treatment or needle exchange for IDUs (CSIS, 2011). It also found that stigma towards IDUs was widespread among the general public and health workers. Local non-governmental organizations (NGOs) were found to be working on HIV prevention among IDUs but were overstretched and did not provide methadone substitution or needle exchange services. In addition, although needles and syringes are available for purchase from pharmacies and other outlets, it was reported that pharmacists were reluctant to sell syringes to IDUs (CSIS, 2011). In 2010, harm reduction services for IDUs remained absent in Kenya (WHO/UNAIDS/UNICEF, 2011).

In 2011, NACC announced a plan to provide free HIV prevention and treatment for IDUs (UNAIDS, 2011). Included in the plan were previously disallowed harm reduction methods including needle exchange and neglected services such as psychosocial support for IDUs. Despite the fact that opioid substitution therapy (OST) has not been banned in Kenya, the availability of OST has traditionally been severely restricted. As part of the new prevention plan, twelve primary health care centres in Mombasa began to offer OST in 2011. The Kenyan government also had announced that, with funding from the Global Fund, it would pilot needle exchange programmes in two public hospitals, one in Nairobi and the other in a coastal city (UNAIDS, 2011).
In 2003 only 5% of people needing ART were receiving treatment (WHO/UNAIDS/UNICEF, 2007). In 2006 Kenya’s President announced that ART drugs would be provided free in public hospitals and health centres. By 2007 treatment coverage was low at 42% with only 172,000 on treatment (UNGASS, 2010) but by 2009 the number of people receiving ART had significantly increased to 336,980. However, due to a 2010 change in WHO treatment guidelines, which recommended starting treatment earlier, the proportion of eligible people receiving ART remained at 48%. Under the previous guidelines, treatment coverage would have been 65%. By 2010, access to treatment had increased further with 432,621 people receiving treatment, representing around 61% of those in need (WHO/UNAIDS/UNICEF, 2011).

Research points to the fact that about half of those infected with tuberculosis (TB) are co-infected with HIV in Kenya (WHO, 2009) although this varies widely according to region. Antiretroviral treatment for co-infected individuals has been found to improve patient survival if administered as soon as possible after TB treatment (Karim, et al., 2010). Therefore, WHO has recommended ART for all HIV and TB co-infected patients, whatever the stage of HIV progression. However, facilities where dual treatment is available are limited and many of those who require ARVs alongside TB treatment are not receiving it (Irin/Plus News, 2010, 20th August).

In a nutshell, an estimated 1.5 million people are living with HIV in Kenya; around 1.2 million children have been orphaned by AIDS; and in 2009, about 80,000 people died from AIDS-related illnesses. Besides, many people in Kenya are still not being reached with HIV prevention and treatment services although access to treatment is increasing. More than half of adults who need treatment are receiving it, with around 100,000 additional adults on treatment in 2010 compared to 2009. An estimated 170,000 children are eligible to receive treatment, yet only around 1 in 5 have access to it. This demonstrates that Kenya still has a long way to go in providing universal access to HIV treatment, prevention and care.

Key issues regarding prevalence of HIV in Kenya
A principle aim of the KNASP III (2009/10-2013/14) is to reduce the number of new HIV infections by using evidence-based approaches to HIV prevention. The Strategic Plan outlines six main outcomes:

i. Reduced risky behaviour among the general, infected, most-at-risk and vulnerable populations;
ii. Proportion of eligible PLHIV on care and treatment increased and sustained;
iii. Health systems deliver comprehensive and quality HIV/AIDS services;
iv. HIV mainstreamed in sector-specific policies and sector strategies;
v. Communities and PLHIV networks respond to HIV within their local context; and
vi. KNASP III stakeholders aligned and held accountable for results.

A study conducted in 2009 by UNAIDS showed that the epidemic was changing and that transmission between discordant couples, where one partner is positive and one partner is negative, accounted for the majority of new infections (WHO/UNAIDS/UNICEF, 2011). As a result, prevention for positive people has been identified a key element of Kenya’s new approach to prevention which will, among other approaches, include couple-based testing and encourage partner disclosure and condom use. There is also a distinctly new focus on MARPs including men who have sex with men (MSM), sex workers and IUDs in the KNASP III.

Fertility tends to be higher in rural areas, whereas HIV prevalence tends to be higher in urban areas. Women may face higher risks than men, but if men almost always infect them, rates among men should not be much lower than among women. However, there have been a number of obstacles either preventing people from accessing condoms, or preventing
people from wanting to use them. In particular, Kenyans have often received conflicting messages about condom use. Many religious leaders have expressed opposition to condom use (IRIN, 2007; Moszynski, 2008).

Results from the 2008/2009 KDHS revealed that of the respondents who in the last 12 months had had sex with two or more partners, only 32% of women and 37% of men reported using a condom (KNBS & ICF Macro, 2010). A 2011 study in Kilifi district found that only 1% of married couples regularly used condoms (Papo, et al., 2011). Reports of people washing and re-using condoms during condom shortages indicate that more needs to be done to ensure people have consistent access to condoms (NACC, 2009; IRIN/Plus news, 2011).

It is notable that female condom uptake has been low, and in 2009 there was a reported shortage of female condoms in public hospitals in Kenya’s coastal region (IRIN 2009, 9th March). In the same year Kenyan officials banned a brand of UK produced male condoms after tests revealed that some had leakage. The culture of silence and stigma around HIV/AIDS implies that people are reluctant to seek information about the disease or go for testing. In sub-Saharan Africa, nearly 60% of adolescent girls surveyed were afraid to discuss the use of condoms with their parents for fear of violence.

Women’s Vulnerability to HIV and AIDS

In sub-Saharan Africa close to 61% of those infected are women and adolescent girls. Women and girls are physiologically two to four times more susceptible to HIV infection than men and boys (PAHO, 2007). According to UNAIDS (2007), close to 80% of young women between the ages of 15 and 24 years lack sufficient knowledge about HIV/AIDS and how to prevent it in countries with generalized epidemics. Coerced or forced sex increases the risk of HIV infection. Poor women in particular are often denied basic human rights, including access to education, health care, safe sex, economic and physical security.

Discrimination and violence have been known to render women and girls far more susceptible to HIV infection. The injuries that characterize violent and coerced sex offer a perfect conduit for HIV transmission. Because they are often so powerless, women may be unable to negotiate the conditions under which they have sex with their husbands or partners. Furthermore, male partners may become violent if women refuse their sexual advances. The risk for HIV among women who are victims of GBV is up to three times higher compared to women who have not been subjected to violent behaviour. In Tanzania, researchers found that young HIV positive women were ten times more likely to have had a violent partner compared to HIV negative women their own age (UNAIDS, 2007).

HIV prevalence is generally higher among females in Kenya, but unsafe sexual behaviour rates are generally higher among males (KNBS & ICF Macro, 2010). Many HIV infections among pregnant women occur when they are already pregnant, often long into their pregnancy. Transmission rates may well be higher among pregnant women, but so is the number of risks they face from being infected through unsafe injections or other medical procedures. In 2008/09 HIV prevalence among women was twice as high as that for men at 8% and 4.3%, respectively. This disparity is even greater in younger women aged 15-24 years who are four times more likely to become infected with HIV than men of the same age (UNGASS, 2010; KNBS & ICF Macro, 2010). Kenyan women experience high rates of violent sexual contact, which is thought to contribute to the higher prevalence of HIV. In a 2003 nationwide survey, almost half of women reported having experienced violence and a quarter of women aged between 12 and 24 years had lost their virginity by force (UNGASS, 2008). Often women would be afraid to disclose their status to their husbands because they are worried they may be stigmatized, assaulted or thrown out of the family home (Human Rights Watch, 2008). It has even been reported that women fail to seek antenatal care from fear of their HIV status being disclosed during routine HIV testing (IRIN, 2008).
Since the year 2000, prevention of mother to child transmission (PMTCT) efforts in Kenya have rapidly expanded. There are now more than 3,397 health facilities offering PMTCT services (UNGASS, 2010). In 2010 an estimated 83% of pregnant women were tested for HIV and 43% of pregnant women living with HIV received the most effective ART regimen for preventing the transmission of HIV to their babies (WHO/UNAIDS/UNICEF, 2011). Whilst only half of HIV-exposed infants received ARVs for PMTCT in 2009 (UNICEF, 2010), testing of HIV-exposed infants improved in 2010 with 64% tested by 2 months of age.

Prevention services for pregnant women must continue to grow as HIV transmission from mother-to-child is still high. For example, an estimated 1 in 5 babies born to HIV-infected mothers are infected with HIV and PMTCT services are not available in all the health facilities (UNGASS, 2010; WHO/UNAIDS/UNICEF, 2011). An estimated 180,000 children were living with HIV in 2009, with approximately 19,000 new child infections in 2010, most of which were probably a result of mother-to-child transmission (WHO/UNAIDS/UNICEF, 2011; UNAIDS, 2010). It is believed that these high rates account for the high infant mortality in Kenya (UNGASS, 2010). In August 2009 the Kenyan government introduced the more effective combination therapy to replace single-dose Nevirapine for PMTCT. The government also emphasized the importance of male involvement in PMTCT programmes and in 2010 introduced a KES. 240 million³ campaign to encourage partner testing, exclusive breastfeeding and delivery of ART to more children who needed it.

2.2 Prevalence and forms of gender-based violence in Kenya

Major General Patrick Cammaert (2008) observed that: "It is now more dangerous to be a woman than to be a soldier in modern conflict". Gender-based violence is understood to be "any act of violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life’ (United Nations Declaration on Violence Against Women, 1993).

Gender-based violence is rooted in unequal power relations - social, economic, cultural, and political between males and females. It takes many forms, and can include physical, emotional, or sexual abuse. It can occur in wartime, or in times of peace. While both males and females can suffer from GBV, studies show that women, young women, and children of both sexes are most often the victims. The most pervasive form of GBV is violence committed against a woman by her intimate partner. A renown statesman observed: “Violence against women is perhaps the most shameful human rights violation. As long as it continues; we cannot claim to be making real progress towards equality, development, and peace” (Kofi Annan, UN Secretary-General, “A World Free of Violence Against Women,” 1999).

In Kenya, the forms of GBV vary across traditions/cultures, economic backgrounds and regions, including

- Sexual violence, in forms such as sexual exploitation/abuse and forced prostitution;
- Domestic violence;
- Trafficking;
- Forced/early marriages - for example, in Northern Kenya the culture of “beading” a girl technically binds her to a Moran, further promoting HIV infection especially in the absence of protection during sexual intercourse. Refusal could well lead to physical repercussions by the community gatekeepers and possibly forced sex with the betrothed man;
- Rape; and

³USD 2.8 million at the current rate of KES 85.00.
v. Harmful traditional practices such as female genital mutilation (FGM), family disputes and widow inheritance.

Lack of enforcement and implementation of the law allowing perpetrators to go scot-free has been shown to negate efforts to address GBV. A key informant for this study observed that: "The courts are demanding on time and resources and few women pursue their cases to the end." She further noted:

Sex workers are criminalized and so it's hard to find one reporting about GBV as they will be arrested instead. Police officers are generally sceptical of a prostitute being raped so reporting is an exercise in futility. Quoting the law has not been of any help.

The study participants observed that that most cases of GBV take place in families, communities and institutions including schools, detention centres and religious facilities. Persons in positions of power (e.g. male partners), police, guards, armed forces and armed groups (militia/vigilante) perpetrate GBV. Recent experiences in Kenya have demonstrated that humanitarian aid workers commit GBV against internally displaced persons (IDPs) in camps (IDI with a PEV survivor in Limuru Camp, Kenya).

The consequences of GBV are numerous and they include acute or chronic physical injury, unwanted pregnancy, STIs, HIV/AIDS, urinary tract infections (UTI), fistulas, emotional and psychological trauma, stigmatization, rejection, isolation, depression, increased gender discrimination and death. In some countries, women and girls who have been raped may be treated as criminals and imprisoned or fined for illegal pregnancies. There are indications that the survivors of GBV (including rape, sexual exploitation, and domestic violence) are at heightened risk of being re-abused.

Data analysed by a recent study on domestic violence in Kenya (FIDA, 2012) also reveals that GBV and intimate partner violence is on an upward trend. The study shows that 74.5% of the respondents interviewed in Coast, Nairobi, Nyanza and Western provinces had been physically abused within their homesteads. Similarly in 2004, a study by the same organization established that 40% of women between the ages of 15 and 49 years had experienced partner violence at least once in their lifetime. The findings also revealed that 52% of women reported physical intimate partner abuse at some point in their lives.

According to KDHS (KNBS & ICF Macro, 2010) almost half of Kenyan women aged 15 to 49 years reported having experienced either sexual or physical violence or both. One in five (21%) reported having experienced sexual violence. The majority of sexual violence occurs within relationships, with two-thirds reporting current or former husbands, partners or boyfriends as the perpetrators and only 6% naming strangers. The survey also showed that 12% of the women reported that their first sexual intercourse was against their will. Of the women who have ever been married, the top three perpetrators were current husbands and partners; former husbands and partners; and mothers and stepmothers. Of women who have never been married, the main perpetrators were teachers; mothers and stepmothers; and fathers and stepfathers.

The KDHS 2008/9 module on GBV included questions on situations that would justify GBV among intimate partners. The questions included whether GBV was permissible if: the woman goes out without telling the man; neglects the children; argues with him; refuses to have sex with him; and burns food while cooking. Figure 1 presents the results based on the academic qualifications of the respondents.
Addressing the links between gender-based violence and HIV in the Great Lakes region.

It is clear from Figure 1 that the respondents with no education and those with primary level of education were more inclined to accepting GBV on the account of the women’s behaviour, which is in contrast to those with secondary and higher education levels.

In terms of rural and urban differences, Figure 2 illustrates that going out without permission, neglecting children and arguing with the male partner were considered appropriate grounds for GBV in both contexts.

*Figure 1: Proportion (%) reporting wife beating is justified by highest level of education (Source: KDHS 2008/9)*
Addressing the links between gender-based violence and HIV in the Great Lakes region.

The results show that more rural respondents were inclined to answer in the affirmative on all the five behaviours identified compared to their urban counterparts.

The same data were analysed based on the eight provinces of Kenya and it is instructive to note that Rift Valley, Western, Nyanza, North Eastern and Eastern provinces had an even spread of views regarding conditions that warranted GBV as shown in Figure 3.
An analysis of the results based on the wealth quintiles shows that those classified as the poorest and the poor were more accepting of GBV based on the woman’s behaviour as shown in Figure 4.

![Figure 4: Proportion (%) reporting wife beating is justified by socio-economic status (Source: KDHS 2008/9)](image-url)
The respondents were categorized by gender and the results are presented in Figure 5.

![Figure 5: Proportion (%) reporting wife beating is justified by gender (Source: KDHS 2008/9)](image)

The results indicate that there were no differences between the views held by the male and female respondents, which could be indicative of the normalization of GBV in society. This implies that the reasons for the practice are acceptable to both men and women, yet the latter are the main victims to it.

The survey also established that the most prevalent violence, spousal violence, is not a one-time occurrence, but a current and recurring problem for Kenyan women. Of the women who reported having ever experienced physical or sexual violence, 82% reported having experienced it during the 12 months leading up to the survey. Slightly over one-fifth (22%) of them reported that the violence occurred often.

Even after the Sexual Offences Act of 2006, a law that outlaws sexual GBV such as rape, defilement and sexual harassment, most cases are still mediated by family, religious advisers and other community members, who frequently encourage women to return to violent homes. This study detected a culture of silence in Kenya, as women are socialized to accept, tolerate and rationalize domestic violence and to keep silent about it.

Although women’s and children’s desks exist in most government offices and police posts in urban areas, interviews with representatives from various organizations suggested that there has not been widespread training of the officers on GBV issues and/or appropriate response to sexual violence and the officers do not have the resources to ensure that all sexual-violence related complaints are investigated. For instance, even if a police officer has a heightened awareness and sensitivity about sexual violence, lack of resources may make it particularly challenging to ensure the safety and security of the survivors or of the preservation of evidence.

The study participants elucidated several factors that discourage women from reporting violence against them. Many are unaware of their rights, legal authorities seldom take action when violence is reported, health care centres and police stations keep inconsistent records and the majority of women have relationships with their perpetrators. Violence against women occurs mostly within the privacy of their own homes, which creates a culture of silence as well as a gap between policy-making and effective programmatic responses.
However, despite the slow pace of implementation of the Sexual Offences Act, measures are gradually being put into place. For example, the government has set up a 24-hour emergency call line under the Ministry of Gender, Children and Social Development to report sexual offenses among other complaints. The use of this line and the actions following the reports are yet to be evaluated and documented. One of the survivors interviewed for this study indicated that fatigue of using resources in the pursuit of justice is yet another challenge. In addition, police laxity and threats from the perpetrators and their relatives contribute to the silence.

2.3 Regional and national conflicts in Kenya
Kenya experiences regional conflicts that are mainly resource-based and politically instigated. For instance, the country has systematically experienced political-related conflict since 1992 (every 5 years), the most significant having occurred during the 2007 disputed presidential elections. During the post-election violence period an average of 260 survivors were attended to per month for the months of January to March, 2008 by the Nairobi Women’s Hospital GVRC. The majority were women and children, who ranged in age from 1 month to 105 years. This indicates a failure in the implementation of the Sexual Offences Act and other legislation including the Children’s Act (2001).

Recognizing Kenyan women’s and girls’ vulnerability to violence stemming from the post-election conflict, an inter-agency rapid GBV assessment was initiated in mid-January 2008 in selected sites in North Rift Valley, South Rift Valley, the Coastal Region, Nairobi and Central Province. The preliminary findings of that assessment confirmed the initial reports from Nairobi-based hospitals that sexual violence had increased during the post-election crisis that began on December 30, 2007. Observations by survivors interviewed for this study suggest that perpetrators were exploiting the conflict by committing sexual violence with impunity, and efforts to protect or respond to the needs of women and girls were remarkably insufficient.

The IDIs conducted as part of this assessment identified the following as key factors in national level and cross-border conflict and their relation to HIV/AIDS and GBV.

i. Historical injustices: these have led to some parts of the country being poorer than others, a problem that is compounded by unclear demarcation of boundaries. The government has paid this issue lip service since independence. A representative from AMWIK noted: "the cause of national conflict is the misuse and abuse of resources and the lack of political will to correct injustices."

ii. Land and resource scarcity and inequitable access: competition for scarce resources is a key trigger for both national and cross-border conflict. For example, the inadequate access to water and pasture in the arid and semi-arid lands has led to the numerous inter-ethnic and clan politics in the country including the Tana Delta clashes of 2012.

iii. The men left behind to protect women during conflict, including armed officers, often take advantage of them, as was the case in the Tana Delta clashes of 2012 and among the IDPs in camps in various parts of the country.

iv. Politicization of the masses for individual political benefit especially when the country is preparing for national elections or for by-elections.

v. Normalization of violence and conflict in the homes mainly through the influence of the media on society. It is notable that books, movies and news reporting have made it seem ‘normal’ to be at conflict and/or war.

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*It should be noted that the names of ministries in Kenya are currently being changed and the activities currently undertaken by this ministry now fall under ‘Labour, Security and Social Welfare’.*
vi. Ease availability of small arms as a result of conflict in neighbouring countries, for instance, the in-flow of arms from Somalia that has resulted in insecurity in North Eastern region.

Poverty was perceived by all the participants in this study to underlie conflict. A respondent from MEGEN summed this relationship as follows:

National conflict is due to negative ethnicity, historical injustices, the economic gap between the rich and poor, poor leadership, corruption and the culture of impunity amongst leaders.

Impact of conflict on women

The study participants identified the following as the main impacts of conflict on women.

i. Women who are unable to run from conflict situations stay behind and bear the brunt of the conflict through exploitation, sexual and physical abuse including death.

ii. Women who are uprooted during conflicts become victims as most of the warriors and/or soldiers are young and reckless and use rape as a weapon. A respondent from NACC noted that:

Evidence from rapid assessment of humanitarian situations (IDPs, slum communities, refugees) where women and children are the majority reveal increased cases of sexual assault and exploitation, transactional sex, divorce and separation, forced and early marriages, compromised access to health care services including the uptake of ARV while PEP drugs are not available in camps.

iii. In cases of prolonged conflict women trade their bodies to meet the basic needs for themselves and for their children including food, security and medication.

iv. Women, and particularly those with disabilities, are usually disregarded by their households, communities and aid agencies and endure the full impact of conflict. Disability makes women slow to act and more vulnerable in the event of conflict. The emergency systems are also not friendly to women with disabilities: there is a huge gap in language translators addressing the needs of those requiring support such as the visually impaired, intellectually challenged and mentally ill.
2.4 Government interventions on GBV and HIV/AIDS

Kenya has several pieces of legislation of relevance to HIV/AIDS and GBV whose implementation is at varied levels.

i. The Constitution of Kenya 2010, which has provisions on protection of women, children and other marginalized groups.


The National Gender and Equality Commission (NGEC) was established in 2011 to be the leading national institution central to the realization of gender equality and equity in all aspects of development for a fair and just society, and is mandated to document violations based on gender and sexuality. The Commission is mandated to carry out investigations on gender-based rights and violations and forward them to the relevant authorities. The NGEC has a mandate to promote gender equality in accordance with Article 27 of the Constitution of Kenya 2010 and its target groups include women, youth, children, older persons, people with disability and marginalized groups.

The government has, in view of the Constitution 2010, redrafted and redefined gender-responsive bills, such as the Family Protection Bill of 2009, Marriage Bill of 2009 and Matrimonial Property Bill of 2009. The government has also developed a national framework towards response to and prevention of GBV, and has established the Gender Violence Recovery Centre (GVRC) and the Gender-Based Violence Information System (GBVIS). The Minister for Gender, Children and Social Development, while addressing the 54th Session of the Commission on the Status of Women at the UN headquarters in New York, reported that these and other measures had contributed to an 11.1% decline in GBV cases between 2005 and 2009 and a 5% decline in FGM between 2003 and 2009.

Despite the progress made in legal sector reforms, particularly in terms of the adoption and implementation of the Sexual Offences Act (2006), there are a number of challenges to ensuring that survivors have access to legal justice. The study participants revealed that funding limitations hinder witnesses’ movement to and from police stations and courts. In addition, investigations often last longer than the 24-hour limit to detain a suspect before arraignment, and this period often does not even allow for the conclusion of the medical reports given that a certified doctor must complete an official medical examination report, yet these are few and far between. Even when a medical examination report is successfully completed, it often takes as long as one year for a case to go through the legal processes, and many survivors lose hope or lack financial resources to continue pursuing the matter. In addition, the country does not have legislation that protects women from marital rape, which is not considered a criminal offence under the Sexual Offences Act (2006).

Kenya is party to all major international and regional conventions that protect and promote the rights of individuals including women and children (such as the UN Convention on the Elimination of All Forms of Discrimination against Women, etc.). The UN Security Council resolution 1325 has been integrated into the National Plan of Action and the National Women’s Charter, which are specifically focused on women’s rights. The key challenge has been the implementation of the various charters, both local and international. Indeed, most
of the interviewees observed that the key gap is that neither the legislators nor the citizens understand the available instruments. Lack of preparedness of the authorities to deal with conflict, which is evident through the ad hoc actions taken when such cases arise, calls for planned interventions with the clear intention of protecting women and children who end up being the most affected by conflict.

The interviewees made several observations that put the policy and implementation into perspective, some of which are cited below.

i. The need to establish a platform that utilizes text messaging and social media as early warning systems and hotlines for reporting cases of GBV (for example, Uwiano).

ii. An interviewee at the Kenya Police Desk observed that:

   To implement any of the deterrent and corrective measures to GBV requires a good prosecution process, which is dependent on good investigative officers equally distributed among the over 500 police stations in the country, well presented charge sheets and a well presented case. It is difficult to get this combination in most parts of Kenya.

iii. Communities need to be sensitized and empowered to apply the international and national instruments for protecting women and girls.

iv. A GBV survivor observed that:

   The law is there but who uses it? Even when one reaches the courts getting a conviction is hard. Cases here don’t even get that far due to police complacency. There is also lack of evidence, little resources to attend the court sessions and pressure/threats from the friends and family members of the perpetrator.

This sub-section illustrates that although there are legal provisions on HIV/AIDS and GBV, the implementation remains weak. The survivors of GBV face practical challenges including lack of information, lack of resources and a myriad of procedural barriers that negate efforts to pursue and apply any of the legal platforms.
3.0 LINKAGES BETWEEN GENDER-BASED VIOLENCE AND HIV/AIDS

Research has shown that there is a direct link between GBV and HIV infection, particularly among young women. Adolescent girls in sub-Saharan Africa experience sexual violence on a regular basis. A study conducted by Action Aid in 2008 demonstrated that GBV is a cause and a consequence of HIV in Kenya (UNAIDS, 2010). A multi-country study on women’s health and domestic violence conducted in 2006 by the WHO found that in countries such as Bangladesh, Ethiopia, Tanzania and Peru, violence in the home is widespread and ranges upwards to just over 70%. The situation is not different in Kenya.

Violence or the fear of violence can pose formidable barriers to HIV prevention, care, and treatment, thereby limiting individuals’ ability to know their status and adopt and maintain protective measures ranging from negotiating safer sex to getting and staying on treatment to remaining in school (Gardsbane 2010; WHO & UNAIDS, 2010). Similarly, violence can impede access to basic health information and services, including HIV treatment, care and support. Conversely, a positive test result can lead to stigma, discrimination, isolation, and violence in the home and community, magnifying the vulnerabilities that women, girls, orphans and vulnerable children (OVC), and other at-risk populations already face in pursuing healthy, satisfying and productive lives (Hale and Vazquez, 2011).

Research studies from India, Kenya, Rwanda, South Africa, Tanzania, the United Kingdom, the United States, and Vietnam demonstrate that women who are HIV-positive are more at risk of violence than women who are HIV-negative, and that violence is a major contributing factor to HIV infection (Program on International Health and Human Rights and Harvard School of Public Health, 2009). For instance, cases of HIV infection were reported as a result of sexual violence during the post-election violence that occurred in Kenya following the 2007 disputed presidential elections (Women’s Empowerment Link, June 2008).

Like HIV, GBV has implications for almost every aspect of health and development - from access to and use of health services to educational attainment, economic empowerment, and full enjoyment of human rights. The similarities between these two mutually reinforcing pandemics do not end here. Women, girls, and other at-risk populations’ distinct vulnerability to HIV and GBV are rooted in structural inequalities, i.e. unequal power relations based on biological make-up, gender identity, and sexual orientation that are codified via cultural beliefs and societal norms and reinforced in political and economic systems.

Linking GBV and HIV efforts is both a necessary and a potentially powerful strategy for eliminating the structural drivers of each and achieving lasting results in the fight against both vices. Both require a comprehensive response: one that simultaneously addresses the biomedical, behavioural, social and economic risk factors and implications for the affected populations. Both require well-coordinated, multi-sectoral efforts that address the multiple dimensions through which violence and HIV infection can affect peoples’ lives, including their health, education, social interactions, economic opportunities, safety, legal protection and human rights. And both must be addressed on a continuous basis throughout the lifecycle to ensure lasting results.

The KDHS 2008/9 included the collection of biomarkers for HIV testing and a module on GBV. As indicated earlier, the questions on GBV were not matched to HIV testing. However, Figure 6 presents an attempt by the research team to correlate the results from the two modules to assess whether there is a pattern in the occurrence of GBV and HIV infection based on the 8 provinces.
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Figure 6: Proportion (%) of response on GBV (emotional, physical & sexual) and HIV prevalence

The analysis points to a close link between sexual violence and HIV prevalence across the 8 provinces while physical and emotional violence do not seem to be closely linked.

Figure 7 is a representation of the relationship between HIV/AIDS and GBV with a focus on the key drivers derived from this study.5

Physical violence between people in an intimate relationship can lead to a range of medical problems for the sufferer, such as reproductive health disorders. Open wounds can create passageways for HIV infection. Further, violence between intimates often contributes to HIV transmission by interfering with the ability of partners to communicate openly with each other about safe sex, their HIV status, or ways to reduce the risk of infection. Where partners cannot speak freely about safer-sex practices, condoms are not likely to be used. Some women may avoid speaking about condoms with a partner for fear of violence.

The immature genital tract and lack of power against adult sexual aggressors place children at risk of HIV infection from sexual abuse and child prostitution. Similarly, adolescent females are placed at risk of HIV infection from rape and coerced sex, economically-motivated sex, forced prostitution, and courtship or date rape. Violence that contributes to the HIV risk of women in their adult reproductive years includes: intimate partner violence; marital rape; violent retaliation of husbands or partners at the suggestion of condom use; and forced prostitution. Women later in life may be particularly vulnerable to violence as a result of economic insecurity and (in some communities) diminished social status. Violence against older women can include rape and violence between intimates, both of which pose a

5Figure 7 is a construction of the author based on the research findings.
risk of HIV transmission. The behaviour of some MARPs, such as bar hostesses and sex workers including alcohol consumption and substance abuse lead to low judgment and those infected do not adhere to ARV use due to the same habits. Furthermore, the consumption of alcohol and other substances impair the ability of the women to adhere to treatment guidelines. The abuse of such substances was also reported by study participants to interfere with the efficacy of the drugs.
4.0 MALE INVOLVEMENT AND INTERVENTIONS LINKING HIV/AIDS AND GBV

The role of men as key partners in the fight against HIV/AIDS and GBV has been recognized and has increasingly become part of interventions in the last 20 years. This recognition, although mainly focused on them as perpetrators of violence, has increasingly shifted to men as victims as well. What is evident is that social value is fundamental to both men’s and women’s identity, self-esteem and to gender and inter-generational relations (Silberschmidt, 2001). Several authors (including Cornwall & Lindifrane, 1994; Cornell, 1995, Bourdieu, 1998, Silberschmidt, 2001:658) have shown a linkage between masculinity, sexuality, manifestations of sexual power and violence. There is also recognition that masculinity, like femininity, is always liable to internal contradictions and historical disruptions. The study team talked to three male organizations to get their views on the study objectives: Men Engage (MEGEN); Men Engage Kenya Network (MENKEN) and Health Options for Young Men on HIV/AIDS/STIs (HOYMAS).

A respondent from MEGEN stated that:

The rising cases of males as victims needs to be interrogated more. It is an aspect of GBV that is not addressed. This could be due to women’s empowerment, women standing up for their rights or as is the case of Nyeri County, the men who are gatekeepers are denied essential services by the women folk. There is a need for deeper understanding of the dynamics and undertake programming based on this understanding.

It is notable that the increase in cases of violence against men could be a factor of increased reporting rather than incidence. This implies that although men have always faced abuse, they have now acquired a voice and with the help of male focused organizations and the media, they are able to come out and report on their experiences.

A representative from MENKEN highlighted the following factors as having led to an increase in men being victimized:

The media is sensationalizing the issues of men as victims of GBV. The harsh economic times are challenging men’s responsibilities and they resort to violence to reassert their positions as heads of households.

The results of a national study conducted in Kenya on gender issues illustrated the brutal nature of violence. Some of the people interviewed noted that it was as if the violators were protesting. Indeed, the study’s conclusion was that the empowerment of women coupled with difficult economic times, which have impacted male-dominated means of income generation, have disempowered some men to the extent that their recourse is physical violence to put the women in their rightful place (Amuyunzu-Nyamongo & Francis, 2006).

While there is legislation against GBV and other forms of violence, issues concerning men have not been clearly articulated, which negatively impacts on the implementation of policies focused on addressing gender issues. Indeed, the Sexual Offenses Act (2006) does not recognize men as victims of violence but as perpetrators. Furthermore, the Gender Desks in the various ministries and police stations were considered gender insensitive by the study participants. According to a respondent from HOYMAS, affected males are reluctant to visit such desks due to the fact that the officers may not be sensitive to their needs given the socialization that deems to project men as the superior/stronger gender: they fear ridicule from the officers who might consider them weaklings. Furthermore, the rampant stigma and
Addressing the links between gender-based violence and HIV in the Great Lakes region.

discrimination towards the gay population makes it difficult for some affected individuals to seek care when needed.

Examples of interventions on HIV/AIDS and GBV
The participants in this study identified both national and international examples of interventions that can be scaled up to address both HIV/AIDS and GBV. Some of these initiatives are summarized below.

National
i. The National AIDS Control Council (NACC) supported the implementation of “Fanikisha” project, which has strengthened institutions to function as “Portals for Health” that provide comprehensive healthcare including HIV/AIDS and GBV.
ii. Bar Hostesses Empowerment Support Programme (BHESP) is a unique intervention that is community led without donor dependency. The programme focuses on the SRH of sex workers and bar waiters with the aim of preventing HIV/STI infections, unwanted pregnancies and GBV. The group has developed partnership with Sex Workers Outreach Programme (SWOP) clinics and drop-in centres.
iii. Men Engage, whose focus is domesticating international campaigns especially at the rural level, reaches out to areas that are often neglected. The organization’s main focus is GBV, HIV prevention, SRH and positive fatherhood. It domesticates international campaigns from Men Engage Global such as the Men Care Campaign that seeks to engage fathers in care giving. The organization is also running a project that seeks to engage men and boys in strengthening the implementation of GBV laws and policies in Kenya. It has conducted a policy scan that identifies the gaps in the language of these policies on how they seek to engage men in four thematic areas: GBV, HIV, SRH and Parenting. This project will engage traditional leaders towards policy implementation and GBV prevention. Currently, the project is implemented in three counties - Kenya, Rwanda and Sierra Leone and similar scans have been done in 8 other countries (www.menengage.org).
iv. Mbagathi District Hospital provides a holistic approach for PLHIV. While it involves some level of cost sharing, it works with support groups to provide comprehensive care including HIV/AIDS, TB and GBV.

Examples of global-level interventions
i. Safe houses for GBV survivors to recover or as transitional stops have been reported to respond to the immediate needs of survivors. One-Stop-Centres such as those found in Rwanda, Malawi and South Africa include a police station, hospital and a safe house for survivors all under one roof.
ii. The SWOP programme, which is a global initiative that covers MARPS provides guidance, support and enables member organizations to navigate international instruments that are sometimes difficult to domesticate.
iii. India runs mobile courts that expedite cases thereby according GBV survivors’ access to justice in real time and in familiar environments.
iv. Norway and Sweden have programmes that rehabilitate perpetrators of violence. Data collected on perpetrators are used to track the trends in violence, including GBV and designing relevant interventions.
v. Programmes such as Stepping Stones, Men as Partners, Men Care and the Million Fathers Campaign have proven effective and can be adapted and up-scaled to enhance male involvement in both HIV/AIDS and GBV.
5.0 CONCLUSIONS AND RECOMMENDATIONS ON THE PREVENTION OF GBV AND HIV/AIDS

5.1 Conclusion

Prevention campaigns on HIV/AIDS and GBV conducted in Kenya often do not adequately consider the reality of the daily lives of Kenyan women and the difficulties they face in gaining control over their own sexual lives. The rampant spread of HIV/AIDS and the high prevalence of GBV can only be stemmed if the subordinate position of women is acknowledged and addressed. Moreover, evidence shows that living with HIV can constitute a risk factor for GBV, with women reporting experiences of violence following disclosure of HIV status, or following admission that HIV testing has been sought. Armed conflict/post-conflict and migration (forced or voluntary) are among specific contexts that exacerbate vulnerabilities to HIV/AIDS as well as GBV in Kenya. The study results indicate that adolescents and women, among other sub-groups are more vulnerable to GBV and in turn HIV infection.

The relationship of HIV infection to GBV is mainly through intimate relations that are influenced by socio-cultural factors including gender power imbalances. It is evident that social factors such as the unfavourable economic position of women, and the inability to insist on condom use make Kenyan women unable to negotiate the timing of sex and the conditions under which it occurs. Thus, they are rendered powerless to protect themselves against HIV infection. Conversely, men are increasingly experiencing GBV due to changing social dynamics including different sexual orientations and their economic disempowerment. Even in war, as men use sex as a weapon, they expose themselves to HIV and STI infections.

To break the silence and strengthen the linkages between HIV/AIDS and GBV, the government needs to mainstream gender and children’s rights programmes, as well as engage men in the prevention of and response to GBV. It is notable that Kenyan women have not been adequately empowered and those empowered are under constant threat of abuse to bring them down to their level. While gender mainstreaming has not been given sufficient attention (as evidenced through the efforts of the 10th Parliament to change the gender equality provisions as contained in the Constitution of Kenya 2010), leading to poor economic rights and employment opportunities for women, men continue to dominate and to perpetrate acts of GBV. Although NGOs, including male-focused organizations, have played and continue to play a key role in addressing HIV/AIDS and GBV, their efforts are limited in scope and time.

5.2 Recommendations

The recommendations are presented in three parts: policy; programmatic; and research.

Policy recommendations

i. Align the current legislation on HIV/AIDS and GBV with the Constitution of Kenya 2010 to ensure their relevance in the current contexts using a language that addresses both boys and men. Such alignment would require re-drafting and tabling the revised legislation in Parliament through the relevant committees.

ii. Ensure the implementation of the various legislation on GBV and HIV/AIDS at the national and county levels. This would require joint actions between non-state actors
working together with state institutions such as the NGEC and GBVCs to advocate for the implementation of the same at the national and county levels.

iii. Monitor the implementation of international and national commitments on GBV and HIV/AIDS at the national and county levels. This would require advocating for specific commitments and working with civil society groups to help hold the legislators accountable.

Programmatic recommendations

i. Social, economic and legal gender inequalities in Kenya need to be addressed in line with the Bill of Rights as provided for the Constitution of Kenya 2010. Doing so would reduce the disproportionately high HIV prevalence among women and the high levels of GBV.

ii. Strengthen judicial processes and enforce deterrent sentences while more strict prosecution of perpetrators is ensured. Measures should be put in place to understand and document the dynamics that contribute to conflict and violence and establish effective mitigation.

iii. Government response should be more strategic and holistic in order to safeguard the lives of Kenyans with effective early warning systems. The mitigation strategies should include the health sector and provision of psychosocial support to the survivors. Mechanisms to rehabilitate the perpetrators of violence should be defined, tested and evaluated for feasibility and sustainability. The government should take the lead in implementing these measures.

iv. Utilize existing HIV/AIDS infrastructure (such as VCT centres) and GBV interventions (such as the Nairobi Women’s Hospital and Kenyatta National Hospital GVRC) to drive the joint HIV/AIDS and GBV agenda.

v. Strengthen NGEC through providing it with a sufficient budget to guide, monitor and evaluate joint HIV/AIDS and GBV programming. Currently, there is little linkage between implementers working on HIV/AIDS and GBV, yet as shown through this study, these two epidemics are closely linked.

vi. Community level structures, such as the council of elders, youth, women and religious groups could be utilized to coordinate with the legal structures to sensitize the citizens on the superiority of the law and how to make use of it.

vii. Performance contracting should include gender mainstreaming, which would require inputs from the NGEC.

viii. Expand the scope of gender programming to include boys and men and ensure that the officers responsible for gender are trained to handle males who are abused by their intimate partners. This is due to the fact that the culture of silence is particularly loud where men are concerned.

ix. Sensitize aid workers and enforcement officers on managing conflict situations. In addition, strict measures should be put in place to hold them accountable for their actions.

x. Establish an investigative unit within the National Council for People with Disability to assess and document cases of abuse especially in institutions that are expected to protect those with disability but end up perpetrating GBV.
Research recommendations

i. Given the importance of gender as a determinant of risk exposure to both GBV and HIV/AIDS, it is critical that further research be conducted in Kenya to assess and confirm the identified causal linkages between the two epidemics. Data should be disaggregated based on gender, physical ability/inability, age and sexual orientation to inform programming.

ii. Research is needed to understand the feasibility of joint actions on HIV/AIDS and GBV including budgeting.

iii. The effectiveness of early warning on conflict should be assessed through action research.

iv. Investigate and document the experiences of both HIV/AIDS and GBV among men and women during conflict. For example, those in camps and returnees – soldiers and community members.

v. Investigate and document the levels of abuse among and against homosexuals as a special group with the view to providing evidence for policy and programming.

vi. Assess the role of media in GBV and how to ensure that there is transformative gender reporting.
6.0 REFERENCES

## Annex 1: List of people and organizations involved in the study

<table>
<thead>
<tr>
<th>No</th>
<th>Name</th>
<th>Organization</th>
<th>Position</th>
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<tbody>
<tr>
<td>1</td>
<td>Esther Gachanja</td>
<td>UNFPA</td>
<td>National Programme Officer (Gender and Advocacy)</td>
</tr>
<tr>
<td>2</td>
<td>Alice Marangi</td>
<td>Federation of Women Lawyers (FIDA)</td>
<td>Programme Officer: Community and Civic Engagement</td>
</tr>
<tr>
<td>3</td>
<td>Abigail Ambiyo</td>
<td>United Disabled Persons of Kenya (UPDK)</td>
<td>Assistant Registrar: HIV/AIDS division</td>
</tr>
<tr>
<td>4</td>
<td>Marcella Wanjiru</td>
<td>Kenya Police</td>
<td>Superintendent of police</td>
</tr>
<tr>
<td>5</td>
<td>Karanja Moraya</td>
<td>Social Welfare and Development (SOWED)</td>
<td>Executive Director</td>
</tr>
<tr>
<td>6</td>
<td>Pascaline Kangethe</td>
<td>Action Aid</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Joyce Chimbi</td>
<td>Africa Women and Child Feature Service (AWC)</td>
<td>Programme Manager</td>
</tr>
<tr>
<td>8</td>
<td>Hellen Otieno</td>
<td>Women fighting AIDS in Kenya (WOFAK)</td>
<td>Gender Programmer officer</td>
</tr>
<tr>
<td>9</td>
<td>Michael Onyango</td>
<td>Movement of Men against AIDS in Kenya (MMAK)</td>
<td>Director</td>
</tr>
<tr>
<td>10</td>
<td>Joyce Nyarwai</td>
<td>Association of Media Women in Kenya (AMWIK)</td>
<td>Programme Officer</td>
</tr>
<tr>
<td>11</td>
<td>Catherine Githae</td>
<td>Men Engage Kenya Network (MENKEN)</td>
<td>Project coordinator</td>
</tr>
<tr>
<td>12</td>
<td>Fredrick Nyaga</td>
<td>Men Engage Kenya Network (MENKEN)</td>
<td>National Coordinator</td>
</tr>
<tr>
<td>13</td>
<td>Philip Eric Otieno</td>
<td>Mens for Gender Equality Now (MEGEN)</td>
<td>Executive Director</td>
</tr>
<tr>
<td>14</td>
<td>Patricia Mundia</td>
<td>CRADLE</td>
<td>Assistant Programme officer</td>
</tr>
<tr>
<td>15</td>
<td>Jared Onsongo</td>
<td>Kenya Women Parliamentary Association (KEWOPA)</td>
<td>Project Associate, Communications</td>
</tr>
<tr>
<td>16</td>
<td>Audrey Mugenzi</td>
<td>Network Empowerment of people with HIV/AIDS in Kenya (NEPHAK)</td>
<td>Assistant Program officer</td>
</tr>
<tr>
<td>17</td>
<td>John Wafula</td>
<td>Liverpool VCT</td>
<td>Gender Technical Manager</td>
</tr>
<tr>
<td>18</td>
<td>Peninah mwangi</td>
<td>Bar Hostesses Empowerment and support program (BHESP)</td>
<td>Executive Director</td>
</tr>
<tr>
<td>19</td>
<td>Carol Nganga</td>
<td>Centre for Rights and Education Awareness (CREAW)</td>
<td>Programme officer</td>
</tr>
<tr>
<td>20</td>
<td>John Mathenge</td>
<td>Health Options for Young Men on HIV/AIDS/STI's (HOYMAS)</td>
<td>Founder</td>
</tr>
<tr>
<td>21</td>
<td>Alberta Wambua</td>
<td>Gender Violence Recovery Centre, Nairobi Women Hospital (GVRC)</td>
<td>Programme manager</td>
</tr>
<tr>
<td>22</td>
<td>Eunice Odongi</td>
<td>National AIDS Control Council (NACC)</td>
<td>Gender Specialist</td>
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Annex 2: In-depth Interview Guide

GENDER BASED VIOLENCE AND HIV/AIDS IN KENYA

IN-DEPTH INTERVIEW GUIDE FOR INSTITUTIONS ENGAGED IN PROGRAMMING ON THESE TWO ISSUES IN KENYA

Date of the interview: __________________________________________________
Name of the interviewer: _______________________________________________
Name of Institution: ______________________________________________________
Name of respondent: ___________________________________________________
Position in the institution:_______________________________________________

Introduction

Good morning/afternoon. My name is............................................. I am involved in an assessment aimed at understanding the levels and trends in gender-based violence and the link to HIV/AIDS in the region. The assessment is being conducted in Kenya and other countries in the Lake Region. Your institution has been selected to participate in this assessment because of the work you do on…………….. I, therefore, kindly request you to share your honest views on the issues we will be discussing.

Your participation in this interview is voluntary and you are free not to respond to any issues you feel uncomfortable with and this will not affect you in any way. I would like, however, to assure you that the information you provide shall be kept confidential and will only be used for the purposes of this study. This interview will last approximately 45 to 60 minutes.

Do you have any question or comment before we proceed? 

Interviewer: (If any question/comment, please first address them before proceeding with the interview).

I also wish to kindly request you to allow me to tape-record this interview so that I can capture everything we discuss.

Interviewer: In case, the respondent refuses tape-recording, do not use the tape but proceed with the interview and write down as much as you can.

1. Organization’s focus
   • What areas of work is your organization involved in?
   • What changes have you observed on women’s health in Kenya? Probe on legislation and programming

2. Perceptions towards GBV in Kenya
   • What is your view regarding gender-based violence (GBV) in Kenya?
   • What are the key factors that contribute to GBV in Kenya?
   • What is your opinion regarding the increasing reports of men as victims of GBV in Kenya?
   • What is your view regarding the legal framework on GBV in Kenya? Probe on the positive and negative aspects of legislation

3. Views regarding HIV and its trends in the last 5 years
   • What in your view has been the trend of HIV transmission in the last five years? Probe on whether transmission is reducing, increasing or stable. What has contributed to this observed trend over the last five years?
   • What factors contribute to HIV transmission? Probe on socio-economic factors, culture, religion, age, gender, and geography

The emphasis of the interview will depend on the expertise and area of focus of the Institution involved in the assessment.
• What have you observed as the role of legislation on HIV programming in the country? Probe on the existing legislation on their positive and negative aspects
• In your view, what has been the impact of organizations working towards male involvement? Probe on whether the respondent is aware of such organizations

4. Regional and national conflict and its impacts on GBV and HIV/AIDS
• The country has in the recent past experienced various forms of conflict, in your view what is the main source of regional conflict? What is the main source of national conflict?
• How does conflict impact on women? Probe on GBV, HIV transmission and other forms of abuse
• What actions are in place to safeguard women against such abuse? Probe on the strengths and weaknesses of such measures

5. Link between GBV and HIV/AIDS
• What do you see as the linkages between GBV and HIV? Probe on culture, poverty and vulnerability of women to both ills
• What instruments are in place to address both? Probe on vertical nature of programming in the country
• In your view, what measures could be put in place that would address both problems? Probe on resource and capacity issues

• What legislation exists nationally to address both GBV and HIV/AIDS? What are the strengths and weaknesses of the current legal framework?
• What are some of the challenges of applying legislation related to GBV and HIV? Probe on cultural and religious issues
• What is the level of implementation of international instruments in Kenya? Probe on knowledge among legislators and citizens

7. Level of programming on GBV
• What interventions currently exist on GBV? Probe on their strengths and weaknesses
• In your view, what are among the best practices in the country? What makes these practices stand out?
• What are some of the best practices in other countries? Probe on what Kenya can learn from the best practice

8. Level of programming on HIV/AIDS
• What interventions currently exist on HIV/AIDS? Probe on the strengths and weaknesses
• In your view, what are among the best practices in the country?
• What are some of the best practices in other countries? Probe on what Kenya can learn from the best practice

9. Suggestions towards improving GBV and HIV/AIDS interventions in the country
• What measures do you think are urgently required to address GBV and HIV/AIDS in Kenya and in the Lake region?
• What joint actions are necessary between the implementers of GBV and HIV/AIDS interventions to comprehensively address the two issues?
• How can coordination between the implementers be strengthened to provide a framework for joint actions?
• What are your key policy recommendations?


Addressing the links between gender-based violence and HIV in the Great Lakes region.


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