Building Partnerships, Transforming Lives

Women and ARVs for HIV prevention: what do we need to think about?

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ARVs for HIV prevention

ARV and preventing vertical transmission

NOTES:
- Women are not homogenous (age, capacity, social – economic status, etc)
- Women’s and men’s sexual experiences are not static
All which inform ability to prevent HIV and respond to interventions

Pre-Exposure Prophylaxis & post exposure prophylaxis
ARVs for HIV prevention?

“Lets say I have a boyfriend and am against the act, but you can be forced. He will come at night when he knows I am there because he want to do …, and to make me to give him. He knows if he rapes me... and when others get to know, they will reject and laugh at me saying I was raped – so I will give in”

(adolescent female, 16yrs, Thika - 2004)

The basics:

- Diagnosis, initiate treatment, adherence, ‘risk reduction’
- How possible is this for this adolescent

Note: data suggests most adolescent sex is not consensual
Outline

- HIV prevention for women?
  ● re-conceptualizing risk
  ● ‘know our epidemic’

- The place for ARVs?
  ● reducing HIV transmission
  ● reducing HIV acquisition

- HIV programming?
  ● HIV Programmes and service delivery disparities
Current HIV prevention focus - ‘risk’

What is HIV ‘risk’?
HIV ‘risk’ is unprotected sex with an individual/s of unknown or discordant HIV status

Who is ‘most at risk’?
Any one who is most likely to have unprotected sex with an individual/s of unknown HIV status or discordant status

But,
- Risk defined by populations, not individuals
- Women not a population at risk
- Kenya: highest prevalence, high incidence, women 15-24yrs 4x more likely infection
Kenyan context

- **sexual practice and behaviour**
  - Based on perceptions of masculinity & femininity
  - Framed within socio-cultural norms
- **Males** – more decision making power in sexual relations
- **Blurred boundaries** - consent, coercion & force with -ve implications for seeking HIV services (*Kilonzo et. al, 08*)
- **Gender based violence**
- **Perceptions of low/no risk among married women** (*KDHS 2007*)

- drivers of sex: desire to reproduce, pleasure, livelihood
- HIV ‘risk’ drivers: vulnerability (Pre-disposition due to *biological, social & structural factors* where individuals have limited control over sexual, behaviour, decisions, practice)
- Women’s vulnerability: age, sex, marital status, socio-economic status, occupation (overlay mapping of vulnerabilities & HIV??)
Kenya’s Modes of Transmission study (Know your epidemic): where are the women?

- **generalized epidemic**
  - 44% new infections
  - couples, MCP

- **concentrated** - key populations

- **No gender disaggregation**

- **No vulnerability framework**
A shift from ‘risk’ to vulnerability frameworks in HIV response is urgently required
Reducing HIV transmission: ART as prevention

- How do we identify ‘high risk’ in general populations– GBV alcohol?
- Community systems – optimal to find women, track and f/u for retention, adherence etc – are we investing?

(Granich et al 2009)
- Annual testing by all >15yrs; Immediate ART start (HIV +)
- Re-testing for ‘high risk’
- High adherence with ART; low failure with first line ART
Reducing HIV transmission: ART as prevention
= Universal Access to knowledge of HIV status

- **HTC:**
  - focus on individual behaviour, sex- socially constructed
  - Missed opportunities for couple HTC

- **For individuals or couples testing HIV –ve:**
  - standard infor vs targeted risk behaviour (learning from HIV +ve post test interventions)
  - specific vulnerabilities ignored e.g. alcohol, GBV
  - no f/u for HIV –ve individuals/couples

- **Service delivery**
  - Links to other services – very weak
Reducing HIV transmission: Prevention of vertical transmission

- P ‘M’ TCT – nomenclature - male involvement ever a possibility?
- **Current focus:** ART use (pregnancy & delivery); early post partum visits result in increased contraceptive use

Is elimination of vertical transmission an achievable goal? (programming & targeting challenges)

- many women (RH age) – don’t know HIV status (HTC?)
- there are new infections among women
- ALL HIV+ women do not have access to contraception (SRH/HIV integration?)
- will all women be able/want to access a facility at birth?

**Is this a case of wiping the floor without turning off the tap?**
Reducing HIV acquisition?

Bottom line... Changing complex context specific interacting social factors that increase vulnerability (ability to negotiate safer sex in the social context, adopt safer bhvrs)

- Transforming gender norms
- Policy and legal environments (prioritization, financing, reporting requirements)
- Interpersonal/social levels (gender power relations, cultural considerations, decision making, ownership)

- PrEP and PEP ...
  - Identifying/reaching women in need of services
  - Women’s ability to access and adhere to treatments (point of care technologies, investment in social changes e.g. lessons from VCT?)

Re-organizing service delivery?
HIV programming and service delivery:

Can we deliver HIV prevention for women?
The health care system in Kenya
Premised on health sector reforms & international paradigms
Dual approaches - common in sub-Saharan Africa

**Horizontal approaches**
- Decentralized management
- Focus on public health & wide range of approaches
- Utilize health care systems
- Limited infrastructure & capacity development

**Vertical approaches**
- Managed from the centre
- Single purpose machineries – facilities, HR, logistics, training
- Focus on specific issues - TB
- Challenges of local ownership

- Women - access, affordability, quality of care
- Interest in the service (desire vs ability for hospital births)
- Unfriendly services that focus on programme design and not the need state of the end user
## ARVs – delivering on prevention?

<table>
<thead>
<tr>
<th>Service required</th>
<th>Location at MOH</th>
<th>Service-local</th>
<th>Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>ART - testing,</td>
<td>NASCOP</td>
<td>Any SDP</td>
<td>Vertical</td>
</tr>
<tr>
<td>CD4, viral load</td>
<td>National Ref labs</td>
<td>Local Lab</td>
<td>Hor</td>
</tr>
<tr>
<td>Adherence Counseling</td>
<td>NASCOP</td>
<td>VCT/DCT</td>
<td>Vertical</td>
</tr>
<tr>
<td>PMTCT - Testing,</td>
<td>NASCOP</td>
<td>Any SDP</td>
<td>Vertical</td>
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<tr>
<td>SRH &amp; FP services</td>
<td>DRH</td>
<td>MCH clinic</td>
<td>Hor</td>
</tr>
<tr>
<td>Child birth</td>
<td>DFH</td>
<td>Obs/gyn ward</td>
<td>Hor</td>
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<tr>
<td>STI services</td>
<td>NASCOP/DRH</td>
<td>STI clinics</td>
<td>Vertical</td>
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<td>Data/records mangt</td>
<td>MoH M &amp; E</td>
<td>District Records</td>
<td>Hor/Vertic</td>
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<td>HIV PEP: evaluation, legal documentation</td>
<td>--</td>
<td>Casualty</td>
<td>Hor</td>
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<tr>
<td>EC</td>
<td>DRH</td>
<td>MCH clinics</td>
<td>Hor</td>
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**Where are the links to community based services that optimally reach the majority of women? Are we investing?**
Challenges in programming?

- Acceptability is difficult
  - vulnerability, more complicated to unpack than risk
  - ‘socially sensitive issues’ e.g. GBV, alcohol use/abuse

- Number based coverage indicators
  - most people, not most needy
  - quality of care compromised

- Capacity for programming, analysis

BUT, WHAT IS THE COST OF NOT INVESTING ON A FOCUS ON WOMEN?

‘.. the needs of the married, particularly women have been neglected... despite the fact that more than half of HIV infections in the severe epidemics of ESA are occurring in this group... (Dlevaux 2007)
In conclusion...

- political will to make ARVs and HIV prevention work for women?

(programmers, government, development partners, academics)

- Use the existing evidence for national programming?
- Design & invest in programmes based on end user and not just programatic gains?
  - long-term commitment in resources?
  - no quick gains in numbers especially structural and social factors/interventions?
- Address women and girls as a priority – while they are not ‘key populations’?
- Transforming gender norms – desirable? must do?
LVCT – an indigenous Kenyan NGO
country led, country managed, country
priorities
1. HTC as entry for prevention
   - VCT; Home-based HTC; Mobile;
     Celebrity; Workplace (>3M tested)
2. Linking testing to care/ART/SRH
   - 21,000 HIV +individuals, models for
effective referrals (e.g. VCT+ model-97% referral uptake), tracking & retention
3. Vulnerable & at risk populations
   - MSM/Prisons - 21,000 tested, 121 on Rx
   - Disability - 20,000 tested, Award winning
     Deaf VCT sites
   - Youth - one2one youth hotline PPP with
     Safaricom (largest telecommunications
     co. - 30,000 calls); 1.6M tested;
   - Sex workers
   - GBV/Post Rape Care: 13,000 survivors
LVCT - inputs

- Research/Piloting
  - TA for policy reforms (GoK)
  - Systems strengthening
  - Facilitating scale up

Technical, financial and human resources; partnerships

HIV testing & counselling; linking testing to palliative care & ART; HIV/SRH to vulnerable/at risk populations

outputs

- Innovation
  - new service delivery models

Evidence-based policy reforms:
  - national strategies, standards for processes, personnel, scale up with costs, performance indicators
  - sustainable human resource (training – community HIV services, health providers)
  - QA & supervision
  - M&E, data & reporting
  - CSO coordination frameworks

Outcomes

Coverage - access, equity (in both delivery and uptake); Strengthened health systems; New knowledge; GOAL: UNIVERSAL ACCESS

-South to South TA: sub-granting & capacity building for implementers, special needs gps
  - direct service delivery
  - demand creation & advocacy

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Acknowledgements

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  - Conversation

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