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Gender Based Violence in HIV Testing and Counselling Settings in Kenya – A Human Rights Perspective

Bachelor Thesis
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"Violence against women is perhaps the most shameful human rights violation. And it is perhaps the most pervasive. It knows no boundaries of geography, culture or wealth. As long as it continues, we cannot claim to be making real progress towards equality, development and peace."

Kofi Annan: Former Secretary-General of the United Nations
'A World Free of Violence Against Women', United Nations
Inter-Agency Global Videoconference, 8 March 1999
(Source: Jacobs, 2003, p. 8)

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List of Abbreviations

ACHPR	African Charter on Human and People's rights
AI	Amnesty International
AIDS	Acquired Immune Deficiency Syndrome
AU	African Union
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CESCR	Convention on Economic, Social and Cultural Rights
CDC	Center for Disease Control and Prevention
CBO	Community-Based Organization
CCPR	Convention on Civil and Political Rights
COVAW	Coalition on Violence Against Women
CRC	Convention on the Rights of a Child
CRR	Centre for Reproductive Rights
CSW	Commission on the Status of Women
CSW	Commercial Sex Worker
DEVAW	Declaration on the Elimination of Violence Against Women
FBO	Faith-Based Organization
FIDA	Federation of Women Lawyers – Kenya
FHI	Family Health International
GBV	Gender Based Violence
GVRC	Gender Violence Recovery Center
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
IASC	Inter-Agency Standing Committee
IDP	Internally Displaced Person
IDU	Injecting Drug User
IEA	Institute of Economic Affairs
KAIS	Kenya AIDS Indicator Survey
KDHS	Kenya Demographic and Health Survey
LVCT	Liverpool Voluntary Counselling and Testing
MARP	Most at Risk Population
NACC	National AIDS Control Council
NASCOP	National AIDS and STI Control Programme
NGO	Non-Governmental Organization
OHCHR	Office of the High Commissioner for Human Rights

OSAGI	Office of the Special Adviser on Gender Issues and Advancement of Women
PITC	Provider-Initiated HIV Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-To-Child Transmission
STI	Sexually Transmitted Infection
TB	Tuberculosis
UN	United Nations
UDHR	Universal Declaration of Human Rights
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNIFEM	United Nations Development Fund for Women
UNHCR	United Nations High Commissioner for Refugees
VAW	Violence Against Women
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

Executive Summary

Gender-based violence (GBV), and in particular sexual violence, is a serious, life-threatening issue that primarily affects women and children. GBV, also referred to as violence against women is a widespread national public health and human rights issue that needs to be addressed in Kenya. In recent years Kenya has experienced increasing numbers of GBV cases. This issue has now permeated the confines of the HIV testing and counselling (HTC) centres. Research shows that women's rights are violated through rape, sexual and physical abuse, sexual harassment as well as child sexual abuse. GBV is perpetrated either by counsellor to client, client to counsellor or counsellor to counsellor, whereby the woman is the sole victim in all instances. Despite the nature of intimacy involved during HTC not much thought was given to the security of the client or counsellor within the enclosed counselling room. Evidences of GBV highlight the need to address this issue from a human rights point of view so as bring into focus Kenya's obligation to ensure the protection of the rights of women in the HTC settings.

The main goal of this thesis is to show the various human rights that are being violated in HTC. Another aim is to find out the potential for GBV in the various settings of HTC. This has been done by assessing the settings according to three criteria: the structure of the setting, the safety of the client or counsellor and the assurance of quality and control of services. GBV is usually a consequence of gender order established in a society where hierarchy and power relations characterize the relations between women and men. Therefore, this thesis also investigates on how gender and power relations influence GBV in the HTC. This work was researched through a desk review of literature from books, journals, NGO reports and the internet.

HIV testing and counselling is an important strategy in the fight against HIV/AIDS in Kenya as it is an entry point to prevention, treatment and care of HIV/AIDS. HTC services are mostly delivered either through client-initiated voluntary counselling and testing (VCT) or through provider-initiated HIV testing and counselling (PITC). Both models of service are provided within different settings, including community-based (stand-alone and mobile), home-based, workplace and health facility settings. Findings show that stand-alone sites, mobile HTC, home-based and health facility settings offer potential for GBV.

The root causes of gender based violence in the HTC are gender and power relations within the cultural context. Gender relations such as inequality in seeking justice, stigma of

HIV infected people, gender stereotypes, unequal opportunities for the girl child and cultural practices that teach men to be superior and women to be submissive could influence GBV in the HTC context. Additionally, power relations that are engraved in some cultures of Kenya make women more vulnerable to GBV as they are often forced to economically depend on men because of denial of equal rights. Furthermore, Kenya is patriarchal country that often perpetuates male power and control as opposed to women.

GBV within the HTC context violates a number of fundamental human rights that are enshrined in international and regional human rights instruments that specifically address VAW and girls. These instruments include the General Recommendation No. 19 of the Convention on the Elimination of All Forms of Discrimination against Women (1992), the Vienna Declaration and Programme of Action (1993), Declaration on the Elimination of Violence against Women (1995) and the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (2003) among others. Analysis of the violation of human rights in the HTC context shows four major human rights that have been infringed on by GBV. First is the right to dignity, liberty and security of person. Female clients are stripped off their human dignity through intimate examinations, rape and molestation of children. In addition, murder threats by male clients violate the female counsellors' right to security. Secondly is the right to be free from sexual violence. Thirdly is the right to the highest attainable standard of health. Health is defined as not just merely the absence of disease but as the complete physical, mental and social well being of a person and therefore GBV hinders the right to enjoy this right. Lastly is the right to be free from discrimination on the basis of sex. Women in the HTC are violated because they are women.

Kenya aims at testing 80% of the population by 2010. However, there is a possibility that only half of this goal will be reached since 83.6% of people in 2007 did not know their results (KAIS, 2007). Efforts to bridge the HTC coverage gap may put issues of quality at hold; therefore it is important that these services are backed up by regular monitoring and Evaluation. The Kenya government has adopted a number of measures to protect the rights of women in HTC e.g. deregistration of counsellors in confirmed cases of GBV. Other measures that could be used include introduction of human rights in the school curriculum and training of counsellors, use of both male and female counsellors in home-based HTC so as to protect the female client and use of a top-down commitment by parliament to ensure the that women's rights are upheld in HTC.

Zusammenfassung (German)

Dieser Arbeit bechäftigt sich mit geschlechtsspezifischer Gewalt in HIV Test- und Beratungszentren. Das Hauptziel ist sexuelle Gewalt insbesondere gegen Frauen und Kinder im Kontext von Menschenrechtsverletzungen zu betrachten. Zusätzlich gilt es auch das Gewaltpotential in den Settings der HIV Test- und Beratungszentren einzuschätzen und den Einfluss von Geschlechts- und Macht-Beziehungen in diesem Rahmen zu erforschen. Die Hauptinformationsquellen sind Bücher, wissenschaftliche Artikeln, NGO Berichte und das Internet. Im ersten Kapitel wird das Probelm beschrieben. Im zweiten Kapitel wird der Begriff der geschlechtsspezifischen Gewalt definiert und die Situation der Frauen in Kenia dargestellt. Das dritte Kapitel stellt die HIV Test- und Beratungszentren, deren Funktion, Prozess, die Arten und Settings, sowie das Geschehen und die Ursachen von Gewalt in den Beratungsräumen dar. Dann folgt die historische Entwicklung der Anerkennung der Frauenrechte und anschließend werden die Menschenrechtsverletzungen in HIV Test- und Beratungszentren hervorgehoben. Ergebnisse zeigen, dass Settings wie eigenständige Einsatzorte, mobile Zentren, Gesundheitseinrichtungen sowie das Zuhause das größte Potential für Gewalt bergen. Des Weiteren tragen Geschlechtsstereotypen, kulturelle Ungleichheiten sowie Ungerechtigkeit dazu bei, dass Frauen in kritische Lagen geraten und schließlich zu Opfern von Gewalt werden. Hierbei werden hauptsächlich vier Rechte verletzt: das Recht auf die Würde, Freiheit und Sicherheit der Person, das Recht frei von sexueller Gewalt zu sein, das Recht auf den höchsten erreichbaren Gesundheitstandard und das Recht frei von Diskriminierung auf Grund der Geschlechtszugehörigkeit zu sein. Maßnahmen zur Eindämmung des Problems sind beispielsweise die Einführung von Menschenrechten im Schullehrplan und in die Ausbildung von Beratern, der Einsatz von weiblichen und männlichen Beratern bei der HIV-Beratung zu Hause, um Schutz für die weiblich Klientinnen zu gewährleisten und das Engagement durch das Parlament, um sicherzustellen, dass die Rechte der Frau sichergestellt werden.

1. Introduction

HIV testing and counselling (HTC) is the main entry point to prevention, care and treatment of HIV/AIDS. The Kenya AIDS Indicator Survey (2007) states that 83.6% of all HIV infected adults are unaware of their HIV status (p. 10) In view of reaching Kenya's goal of 80% testing coverage; Kenya still has a long way to go (KAIS; 2007, p. 10). In light of this situation, Kenya has adopted the concept of Universal Access of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organisation (WHO, NASCOP, 2008, p. VI). Universal Access to comprehensive HIV treatment, prevention, care and support is a global commitment that was made in the Declaration of HIV/AIDS at the United Nations General Assembly in 2006 to increase access to effective HIV interventions in many countries by 2010. By adopting this concept, Kenya is also making a step in achieving the Millennium Development Goal 6 of "*halting and reversing the spread of HIV by 2015.*" To achieve the goal of Universal Access, UNAIDS and WHO are encouraging the scale up of client-initiated and the expansion of provider-initiated testing and counselling services in health care settings (UNAIDS, 2010). The rapid scale up of HTC services in Kenya has led to great achievements. According to the report of the United Nations General Assembly Special Session on HIV and AIDS (UNGASS, 2010), 3,471,567 people above the age of 15 years were tested of HIV in 2009 alone (NACC, 2010, p.11). In addition, the number of women and men tested increased from 13.1% and 14.3% respectively in 2003 to 56.5% and 40.4% respectively in 2008 (NACC, 2010, p. 11). However, this rapid movement of HTC has led to concerns of the safety of female clients and counsellors in the counselling rooms.

1.1 Problem Definition

Research has found that gender based violence exists in HIV Testing and Counselling settings. Three different types of abuse within HTC rooms have been identified: either client to counsellor, counsellor to client or counsellor to counsellor, whereby the woman is the sole victim in all aspects regardless of her professional status. Acts of gender based violence perpetrated in the HTC context include rape, sexual assault, child molestation, sexual exploitation, sexual harassment and physical and sexual abuse.

HTC is conducted on the principal of the "three Cs" - informed consent, confidentiality and counselling. Through this principal, a client is ensured privacy by being counselled in an enclosed room where lack of interruption is guaranteed. Despite the intimacy involved in the discussions between the client and counsellor, there have been little academic

discussions so far on the possibility of gender based violence inside the counselling rooms. HTC is an important tool in curbing the spread of HIV, however if it becomes an entry point to gender based violence, Kenya's goal of universal access will not be reached.

1.2 Objectives and Methodology

This thesis has three main objectives. The first is to identify which HIV testing and counselling settings provide chances for gender based violence to occur. The second objective is to find out how gender and power relations fuel gender based violence in HTC settings. Finally, the third objective is to illustrate the development of women's human rights and to analyse how these rights are violated in HIV testing and counselling in Kenya. There is urgency in looking at gender based violence from a human rights perspective because human rights laws set out standards that should be adhered to by all states that agree to sign and ratify them in their domestic laws. In addition, gender based violence is not only an issue of public health but also of human rights. Research for this thesis was carried out through a desk review of literature on reports related to HTC services as well as to violence against women globally and in Kenya. Sources of Information include books, journals, NGO reports and internet sources.

1.3 Structure of Thesis

The thesis has been divided into five main chapters. The first chapter introduces the topic. The second chapter defines gender based violence and gives a general overview of the issue of gender violence in Kenya. The third chapter handles HTC including its significance, functions, process, types of services and settings. The problem of gender based violence in the HTC room has also been illustrated with the help of a few examples. In addition, examples of gender and power relations that influence gender based violence have been linked to the HTC context. The third chapter illustrates the importance of a human rights perspective and also shows the historical recognition of gender based violence as a human rights violation. The fourth chapter analyses human rights violations in HTC in Kenya. Results of the thesis and their interpretations are found within this chapter. In conclusion, chapter five discusses the results found and also gives recommendations that could be useful in solving the problem.

2. The Issue of Gender Based Violence

Public Health is concerned with the health and well being of a population. Violence inflicts a major burden on this well being. This chapter deals with violence that is imposed on the basis of gender. It also depicts the situation of gender based violence in Kenya.

2.1 What is Gender Based Violence?

The Inter-Agency Standing Committee Taskforce on Gender in Humanitarian Assistance (IASC) defines gender based violence as "*an umbrella term for any harmful act that is perpetuated against a person's will and that is based on socially ascribed (gender) differences between males and females*" (IASC, 2005, p. 7). Gender Based Violence refers to violence that targets individuals or groups on the basis of their gender and includes acts

- that inflict physical, mental or sexual harm or suffering,
- the threat of such acts,
- coercion and other deprivations of liberty

Though women, men, girls and boys can be subjected to gender based violence, the term gender based violence is often interchanged with the term violence against women (VAW) (National Commission on Gender and Development, 2009, p. 6). The United Nations General Assembly (1993) defines violence against women as

> *"any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering for women, including threats of such acts, coercion, or arbitrary deprivations of liberty, whether occurring in public or private life"* (United Nations Special Rapporteur on Violence against Women, 2009, p. 4)

The term "Gender" is defined as the social characteristics attributed to men, women, boys and girls. These social characteristics differ on the basis of age, religion, place, time, and profession, national, ethnic and social origin. They vary both between and within cultures and distinguish identities, status, roles, responsibilities and power relations of members of a culture or society. Gender is dynamic since it is learned through socialisation and responds to changes in the social, cultural, political, economical and technical environment. People are born either female or male (sex), and then they learn how to be girls or boys and women or men (gender). In other words, gender indicates what is means

to be a girl or a boy, woman or man in a certain culture or society where attitude, behaviour, roles, responsibilities, constraints and privileges of women and men, girls and boys have already been set. (National Commission on Gender and Development, 2009, p. 6)

GBV emphasizes the gender dimension of violence against women; in other words, the connection between females' subordinate status in the society and their increased vulnerability to violence (IASC, 2009, p. 7). It is a major public health and human rights problem throughout the world and cuts across class, race, age, religion and nationalities. Violence against women and girls takes place in the home, schools, workplace, health facilities, in farm fields, on the street, in refugee camps, during conflicts and crises. The various faces of VAW include: Sexual violence, including sexual exploitation and forced prostitution, domestic violence, trafficking, forced/early marriages, harmful traditional practices such as female genital mutilation, honour killings, widow inheritance etc. (IASC, 2009, p. 8).

There are 5 types of gender-based violence, these are:

Sexual violence: is defined as

> *"any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work"(IASC, 2009, p. 8).*

It includes rape and attempted rape, defilement, attempted defilement, gang rape, indecent act, sexual assault, sexual harassment, incest by both males and females, deliberate transmission of HIV and any other sexually transmitted diseases, sexual offences relating to positions of authority and persons in position of trust, cultural and religious sexual offences, trafficking for sexual exploitation, child sex tourism, child pornography etc. (Sexual Offences Act, 2006, p. 2)

Physical violence: this is described as the deliberate use of physical force with the likelihood of causing harm, injury, disability or death. It includes, but is not limited to pushing, slapping, shoving, throwing, grabbing, biting, chocking, scratching, burning, use of a weapon, use of restraints or one's body size or strength against another person (CDC, 2009)

Emotional and psychological violence: this is when a victim is traumatized through acts, threats of acts or coercive tactics. Such violence includes humiliation of the victim, controlling the actions of a victim, withholding information from the victim, denial of access to basic resources to the victim, isolation of victim from friends and family and doing things to make the victim feel diminished or embarrassed. Such violence is considered emotional or psychological when there has been prior physical or sexual violence or threats of these (CDC, 2009).

Harmful traditional practices: These are acts of violence that are committed against women in certain communities for so long that they are considered part of the accepted cultural practices (UNIFEM, n.d.). In Kenya such violations consist of female genital mutilation (FGM), early and forced marriage, Infanticide and/or neglect and denial of education (National Commission on Gender and Development, 2009, p. 8*).*

Socio-economic violence: this includes discrimination and/or denial of opportunities and services (e.g. to health, education, employment or property rights), social exclusion/ostracism based on gender (e.g. denial of access to social benefits and public or private hostility) and obstructive legislative practice (prevention of the enjoyment of social, civil, economic and political rights of a person based on their gender, United Nations High Commissioner for Refugees, 2003, p. 18)

2.2 Gender Based Violence in Kenya

Violence against women and girls is widespread in Kenya. According to the 2008/09 Kenya Demographic and Health Survey (KDHS), 39% of women (4,318) have experienced physical violence since the age of 15 years, whereby one out of every four women (24%) experienced violence in the last 12 months before the survey. The survey showed that women who are widowed, divorced or separated are more likely (60%) to be exposed to physical violence, while among the married (42%) or never married (25%) women, a lower percentage suffers from violence (Lumumba & Wanyonyi, 2009, p. 247). Furthermore, results showed that the main perpetrators of physical violence for women who had ever been married were either their current/former husbands or partners and to a smaller extent mothers or step-mothers. As for the never married women, perpetrators of physical violence included teachers, mothers, step-mothers, fathers and step-fathers (Lumumba & Wanyonyi, 2009, p. 248).

In the same study, one out of five women (21% of 4,318) in Kenya has experienced sexual violence. In most cases, sexual violence is perpetrated by persons known to the victims. Among the ever married women, sexual violence is perpetrated mainly by current or former husbands and partners, while for never married women, sexual violence is mostly committed by boyfriends. However, one in five never-married women (19%) reported being sexually violated by a friend or acquaintance, whereas almost as many reported being sexually violated by a stranger (17%).

On the whole, almost half of the women (45% of 6,318) reported experiencing physical and sexual violence between the age of 15 to 49 years. This constitutes, 25% of women who have experienced physical violence, 7% experienced sexual violence and 14% experienced both types of violence. (Lumumba & Wanyonyi, 2009, p. 250-251)

As evident in the 2007 annual report of the Gender Violence Recovery Centre of the Nairobi Women's Hospital, most of the patients (2,348) who receive comprehensive medical examination and treatment have experienced sexual violence (87%) in relation to domestic violence (13%). Out of the 1129 adult survivors of sexual assault, 1076 (95%) were women, and only 53 (5%) were men. Out of the 920 children survivors, 793 (86%) are girls and 127 (14%) are boys. (GVRC, 2007, p.4-6)

Sexual violence against women and girls in Kenya increased during the post-election violence that began on December 30, 2007. Violence erupted in various parts of the country resulting in injuries, deaths and displacement of hundreds of thousands of citizens. Sexual violence was used as a tool to terrorize individuals and families and to hasten their eviction out of the communities in which they lived. Women and children were told that if they did not vacate their property within a designated timeframe, they would be raped. In most cases, such threats were actualized and in certain instances committed by gangs of men who used physical brutality on their female victims. Sexual exploitation is also rampant among the Internally Displaced Persons (IDPs), whereby women and girls are forced into exchanging sex for basic resources such as food, transport, sanitary supplies etc. Other GBV concerns among the IDPs included domestic violence, early marriage and trafficking of young girls as a result of increased poverty and inability of parents to provide for their children. In addition, girls withdrew from schools due to security issues and also so as to help their mothers to manage the increased domestic responsibilities. The increased risk of GBV in the IDP camps can be attributed to the lack of gender equality in camp decision making and coordination processes (Myrum, 2008, p. 2-3)

Violence against women and girls also happens within health facilities. A report by the Center for Reproductive Rights and the Federation of Women Lawyers Kenya (FIDA) reveals devastating mistreatment of women and girls before, during and around delivery. Women describe negligence and abusive treatment they received at the hands of health care providers in public and private health care facilities. They reported being pinched on the thighs, slapped or beaten into compliance during labour by medical personnel (CRR, 2007, p. 31). Furthermore, one woman who delivered at St. Mary's hospital Langata in 2005 also described how a medical provider mutilated her sexual organs (CRR, 2007 p. 32).

From the above examples, it is clear that GBV is rampant in Kenya and that it also happens in hospitals where patients place their trust and reliance on doctors for their treatment. Subsequently, this problem has now permeated the confines of the HIV testing and counselling settings thereby violating the rights of clients and counsellors. This issue will be discussed further in the next chapters

3. HIV Testing and Counselling in Kenya and Gender Based Violence

HIV testing and counselling is the process by which a person undergoes counselling enabling him or her to make an informed decision about being tested for HIV. The decision is made by the individual and he or she has to be assured that the process will be confidential. The objective of HIV counselling is to evaluate a client's risk of HIV transmission and to facilitate preventive behaviour as well as to give emotional support to those who wish to consider HIV testing (UNAIDS, 2000, p. 3). Knowledge of HIV status provides those who are HIV negative the opportunity to remain HIV negative and for those who are positive support through counselling and access to care and treatment.

3.1 Significance of HIV Testing and Counselling in Kenya

The Kenya Aids Indicator Survey (KAIS, 2007) estimated the national HIV prevalence in Kenya to be 7.4% among adults aged 15-49 years while the Kenya Demographic and Health Survey (KDHS 2008/09) estimates it to be 6.3% for the same age group.1.3 - 1.6 million people are estimated to be living with HIV, whereas new infections are estimated to be at 100,000 in 2009 for adults aged 15 and above years (National Aids Control Council, 2010, p. 1). Women are more likely to be infected (8.4%) than their male counterparts (5.4%), while young women (15-24 years) are four times likely to be infected (5.6%) than the men of the same age group (1.4%, KAIS, 2007, p. 9). The proportion of adults aged 15-49 years who reported ever being tested increased from 15.2% in 2003 to 36.6% in 2007. Women were more likely to be tested of HIV (44.6%) than men (25.6%, KAIS, 2007, p. 10). The KAIS (2007) further showed that 83.6% of all HIV-infected adults were unaware that they were infected (p.10). This points out clearly that HIV testing has to increase to a large extent in order to reach Kenya's 2010 goal of 80% coverage of HIV testing of all adolescents and adults (KAIS, 2007, p. 10). With respect to this, HTC has a great significance as it is the cornerstone towards accelerating the attainment of this goal.

Since its introduction to Kenya in 2000, HIV testing and counselling services have rapidly increased from 3 to 555 sites in 2005. This was achieved through the joint efforts of the Kenya government, international donors and partners as well as non-governmental and faith-based organizations. Within the same period, the annual service uptake of client-initiated voluntary testing and counselling (VCT) also increased from 1000 to 380,000 (NASCOP, 2005, p. 28-29). Figures from the 2010 UNGASS report show that 960 client-initiated voluntary testing and counselling sites now exist (NACC, 2010, p. 11).

Until 2004, the client-initiated VCT had been the primary model of HTC services, though a number of people were also being tested through PMTCT services, in hospitals and through other care programmes. By expanding HTC services in health care facilities access to HIV/AIDS care and treatment was also expanded (NASCOP, 2005, p. 29). HTC services are offered in sites that have been registered by the Ministry of Health and are meant to be conducted in accordance to the new 2008 National HTC Guidelines which replace the 2001 National Guidelines for VCT and the 2004 Guidelines for HIV Testing in Clinical Settings (NASCOP, 2005, p. 29; NASCOP, 2008, P. 2).

HTC is an important strategy in preventing HIV/AIDS as it is associated with knowledge and behaviour change that reduces HIV transmission. Knowledge of one's own status can motivate an individual to practice safer sex thereby protecting himself/herself or their partner from contacting HIV/AIDS. With regard to behaviour change, KDHS (2008/09) reports that the proportion of those who use condoms at first sexual intercourse doubled from 11% in 2003 to 24% in 2008-09 among women and from 14% in 2003 to 26% in 2008-09 among men, whereas the proportion of women using a condom at last premarital sexual intercourse increased from 27% and 48% in 2003 to 40% and 64% in 2008-09, women and men respectively (Buluma, Muriithi & Gitonga, 2010, p. 199-201). When it comes to increased knowledge, the proportion of women and men who know that the risk of mother-to-child transmission can be reduced by taking certain drugs during pregnancy has doubled from 33% in 2003 to 69% in 2008-09 among women and from 38% in 2003 to 70% in 2008-09 among men (Buluma, Muriithi & Gitonga, 2010, p. 108).

HTC is an entry point to prevention, care and treatment of HIV and therefore a significant strategy in Kenya's HIV prevention mandate and strategy. In the provision of HTC services, Kenya has adopted a multi-pronged approach. As a result, the number of people tested for HIV between 2003 and 2009 has significantly risen. Alone in 2009, 3, 471,567 people above the age of 15 years were tested of HIV. The rapid scale up of HTC services has contributed to the increase in number of women and men tested from 13.1% and 14.3% in 2003 to 56.5% and 40.4% in 2008 respectively (NACC, 2010, p. 11).

With the aim of improving performance in service provision, Kenya is one of the few countries that have adopted the Rapid Results Approach (RRA). This is a management tool that speeds up the achievement of results within a 90-day period. This approach was used to scale up HTC in 2008 and 2009. Over 700,000 people were counselled and

tested in a week in 2008 and in 2009 the number was 1.2 million in over three weeks. This shows that the demand of Kenyans to know their status is high (NACC, 2010, p. 18).

The three core functions of HIV testing and counselling constitute prevention, treatment and care of HIV/AIDS. As an effective tool in the prevention of HIV, HTC enables individuals to change or maintain behaviours to prevent acquisition or further transmission of HIV (WHO, 2003, p. 1). A population benefits from HTC services in that people have an opportunity to learn and accept their HIV status in a confidential environment. It is also a gateway for people living with HIV/AIDS (PLHIV) to receive antiretroviral drugs and treatment for HIV-associated illnesses as well as other care services, thus improving their quality of life. Pregnant women who are aware of their HIV status can prevent transmission of HIV to their Infants by taking treatment offered at the HTC sites. In addition, knowledge of HIV status helps individuals to protect themselves as well as their partners from the HIV infection (UNAIDS 2000, p. 2). Furthermore, post-test counselling services enable HIV positive individuals to learn how to better cope with the infection (WHO, 2003, p. 1) and inform the client of relevant referrals e.g. medical clinics. Another important function is the provision of psycho-social support e.g. for survivors of rape that is offered by Liverpool Voluntary Counselling and Testing (LVCT) in Kenya. (LVCT, 2008/09, p.17).

In the community, HTC helps to reduce the denial, stigma and discrimination that surround HIV/AIDS through sensitization of individuals, leaders and the whole community such as schools, villages, workplaces and community based organizations. Through provision of accurate information in the HTC sites, myths about HIV/AIDS e.g. that it can be transmitted through witchcraft, or mosquito bites or by sharing food with someone who is infected, are dispelled, thus increasing the understanding of the community about the risk of HIV/AIDS. This can also alleviate fear of living with HIV or associating with people living with HIV/AIDS. Individuals and groups of people who receive information and assistance through HTC then spread what they learn during the HTC process, thereby becoming ambassadors of HIV awareness, anti-stigma messages and behaviour change communication. Furthermore HTC offers a platform for discussing a range of sensitive issues such as sex and sexuality of the youth, communication between partners and personal hygiene, thus contributing to behaviour change within a community (Osanya-Nyyneque, 2009).

HTC also serves to provide data such as HIV incidence and prevalence rates as well as research findings to medical authorities, government policy makers, civil societies, donors

and research groups, who use the information to make plans, design programmes, and formulate strategies regarding HIV/AIDS (Osanya-Nyyneque, 2009). For example, LVCT undertakes research that is utilized to inform policy at different levels.

At the national level, it played a major role in the development of the road-map to achieve Kenya's Universal Access HTC targets and was also the National Quality Assurance Team in developing the National Quality Assurance Strategy for HTC. In the international scene, LVCT participated in developing "Guidance to strengthen provider messages on re-testing and counselling in adults for HIV" by the WHO (LVCT, 2008/09, p. 7). In response to gender based violence, LVCT's study findings of the chain of evidence study (2008/09) have been helpful in reviewing and developing of the National Guidelines on the Management of Sexual Violence in Kenya (LVCT, 2008/09, p. 9).

Kenya embraces different models and settings of HTC. Before looking at the issue of gender based violence in HTC settings, the procedure, models and settings of HTC have been looked into in order to understand the problem.

3.2 The Process, Models and Settings of HIV Testing and Counselling (HTC)

This chapter looks at various components of HTC in general. In addition, the potential for gender based violence in the various settings of HTC is assessed.

3.2.1 The Process of HTC

The UNAIDS/WHO policy statement on HIV testing upholds three core principles of HIV testing and counselling, namely that it is

- confidential
- accompanied by counselling and
- conducted with informed consent, meaning that it is voluntary (UNAIDS, 2004, p. 1)

The counselling process of HTC involves three steps: pre-test, post-test and follow-up counselling.

Pre-test counselling:
This is offered to inform and prepare the client for the test. The client receives an explanation of what a HIV test is and myths or misinformation surrounding HIV/AIDS are

also corrected. This part of counselling involves discussing the clients' personal risk profiles including, sexuality, relationship, factors that increase the risk of infection e.g. sexual and drug related behaviour and HIV prevention methods. The counsellor also explains to the client what it means to know one's serostatus and ways of coping with the information. Some of the information given during this session can be offered to groups so as to reduce costs and can be supplemented by written material.

However, all persons requesting HTC services are to be counselled individually before being tested. In some instances, individuals opt not to be counselled before the test because they have already been tested before. In such cases, these people are not prevented from taking a HIV test. An informed consent thus gives way to the actual testing of HIV (UNAIDS, 2000, p.4).

Post-test counselling:

This follows with the aim of helping the clients to understand their test results and adapt to their seropositive or negative status. Results of the HIV test are conveyed in a clear and sensitive way and emotional support is given to the client.

- If HIV test is positive, the counsellor ensures that the client has emotional support from a partner, relative or friend who accompanied him/her. When the client is ready, information on referral services that may help him/her to cope better are given. The counsellor also discusses with the client about methods of preventing HIV transmission to his/her uninfected or untested sexual partner. This however poses a problem to women who live in abusive relationships and are afraid of facing abuse if they are seropositive (UNAIDS 2000, p. 4-5)
- If HIV result is negative, more emphasis is made on the changes in behaviour that can help the client to stay HIV-negative e.g. safer sex practices including condom use and other methods of HIV prevention. Clients are encouraged to adopt and maintain new safer practices and are also referred to other counselling services and support groups if need be (UNAIDS 2000, p. 5).

Follow-up counselling:

Follow-up counselling is given in subsequent counselling sessions. It is essential as it helps those who are positive to cope better with their life and gives guidance to those who are negative on how to retain their negative status.

3.2.2 Types of HTC

The two major models of HTC in Kenya are Client-initiated HIV testing and counselling and Provider-initiated HIV testing and counselling. However, other models also exist. Following are descriptions of all the models of HTC in Kenya.

Client-Initiated HIV testing and counselling, also known as voluntary counselling and testing (VCT) refers to a model in which, individuals, couples or groups seek out HIV counselling and testing services at sites where such services are offered. The client-initiated model is based upon the individual's own request to be tested of HIV (NASCOP, 2008, p. 4).

Provider-Initiated HIV testing and counselling (PITC) is a model by which the HTC service provider initiates HIV counselling and testing to clients or patients in health care facilities, regardless of their reason for being in the health care facility. PITC not only targets patients with HIV-related signs and symptoms but also opens up its services to pregnant women in antenatal care services, STI patients and to patients who are at risk of contracting HIV infection e.g. injecting drug users (NASCOP, 2008, p. 4). In Kenya, 73% of health facilities (4,939) provide HTC services (NACC, 2010, p. 17).

Self Testing for HIV is a new HIV testing technology that enables testing of HIV upon one self. These HIV tests are non-blood based and commonly constitute oral fluid and urine based testing. The difference to the traditional HTC models is that the client does not get basic education on HIV/AIDS, pre- and post-test counselling (NASCOP, 2008, p.5).

Required HIV testing refers to a mandatory HIV testing that is done in certain circumstances e.g. during the military recruitment or by order of a law court, one is obliged to go for HIV testing (NASCOP, 2008, p.6)

HIV testing of blood and tissue donation: This is done before donating or transfusing blood, whereby an infectious disease screening test has to be passed before the blood is given to a patient (NASCOP, 2008, p. 6).

HIV testing for research and surveillance: HIV testing may be undertaken following clearance from the relevant ethical review committee for the purposes of research or surveillance. An example is the sentinel surveillance that is based on anonymous testing

of pregnant women in antenatal clinics and patients in STI clinics for the purposes of estimating the number of HIV infected persons in Kenya (NASCOP, 2008, p. 6).

3.2.3 Settings of HTC

Settings are areas of life in the society in which people spend most of their time. This can be in homes, schools, hospitals, workplaces, communities or in the neighbourhood. They are therefore social systems where people live, interact, work and play and therefore create perfect places for setting up health interventions such as HIV testing and counselling services.

Though client-initiated HTC takes place in the community and provider-initiated HTC in health facilities, both services are flexible and can be offered in various settings. The aim of using different settings of service delivery is to expand entry points to HIV testing and to promote testing as a routine and modern practice. The settings aim to reach different target groups by providing clinical care to those living with HIV/AIDS or STI, prevention of mother-to-child transmission of HIV (PMTCT) and also serve as a HIV prevention tool for the general population. HTC services are delivered in five types of settings in Kenya: community-based, outreach/mobile, home-based, workplace and health care settings. Below are descriptions of the settings as well as their benefits and challenges. In addition, with regard to the first objective of this thesis - to identify which HIV testing and counselling settings provide chances for gender based violence; the settings have been assessed according to the following criteria:

- Structure of setting
- Safety of client/counsellor
- Quality assurance and control of services

a) Community-based HIV Testing and Counselling

HTC services may be offered in the community so as to strengthen the social elements of HTC for prevention, family level counselling and to provide links to support groups. Examples of community based settings include stand-alone and mobile/outreach HTC.

- **Stand-alone sites**

Stand-alone sites, also known as freestanding sites are facilities that are operated by non-governmental organisations (NGOs), faith-based organisations (FBOs) or other community-based organisations (CBOs). These sites are mostly designed to only offer HTC services. Target groups here include the general population as well as populations with special needs such as the deaf, youth, commercial sex workers (CSWs) and injecting drug users (IDUs, NASCOP, 2008, p. 7). Due to cost-benefit, stand-alone sites are usually situated in highly populated areas and where the rate of HIV infection is high (Family Health International, 2005, p. 1). Approximately 17% of registered HTC sites in Kenya are stand-alone sites (NASCOP, 2005, p. 30).

Benefits and challenges

They offer only HTC services, thus the staff is full devoted to this service and this is in turn makes it easier to control the quality of HTC services. Stand-alone sites attract population groups that would normally not attend health facility HTC e.g. the youth and IDUs. They also offer the opportunity to focus on prevention and risk reduction counselling. In addition, there is adequate staffing and flexible hours of working, thus stand-alone sites are easily accessible. Challenges include high costs of starting-up and operating and therefore these sites require long lasting donor funds to facilitate their work. These sites may lack infrastructure or other support services for medical and psycho-social support. Moreover, there may be high stigmatization of stand-alone sites since they only deal with HIV/AIDS (Family Health International, 2005, p. 1-2). A study reveals that one of the barriers to women accessing HTC in Kenya is that many believe that HTC is for prostitutes (Taegtmeyer, Kilonzo, Mung'ala, Morgan, Theobald, 2006, p. 309).

Potential for gender based violence in stand-alone settings

The following criteria have been used to assess the potential for gender based violence in stand alone sites

Structure of setting: stand-alone sites provide a chance for gender based violence as the counselling rooms are privatized. Furthermore, victims of gender based violence may not be able to access post exposure prophylaxis and ongoing counselling because of lack of medical and psycho-social support in some stand-alone sites.

Safety of clients/counsellors: the nature of privacy involved in HTC makes it necessary for client and counsellor to be in a room where the client's information will not be heard by

others in the HTC center. Because of this, most HTC rooms are often closed during counselling and one cannot tell what is actually going on inside. However, through the use of doors made of glass, privacy as well security for the client can be assured as no can hear the client's private matters but everyone in the HTC site can see what goes on inside the room. This method should apply to all HTC settings that use enclosed rooms for counselling.

Quality assurance and control of services: assurance of quality is difficult since this setting is often operated by private organizations. Control of services may be easier since stand-alone sites only focus on HTC services. However, this does not exclude the potential of gender based violence.

- **Mobile/Outreach HIV testing and counselling**

These are HTC services offered outside a fixed site and are either taken into the community by use of mobile methods or from designated places. Mobile HTC is a strategy to reach most at risk populations (MARP) that work at night, including commercial sex workers, truck and taxi drivers and thus is also referred to as moonlight HTC (NASCOP, 2008, p. 7) Such activity has yielded great results for example in Mlolongo and Nairobi in Kenya, where over 6,000 sex workers and their clients were tested during a 5-day moonlight testing campaign (NACC, 2010, p.11). Other populations that benefit from mobile HTC services include nomads, prisoners, wildlife wardens and their families and street dwellers. This mode of service delivery also serves as a means of overcoming barriers to accessing HTC services and also linking individuals to other services. In Kenya these services are provided by using vehicles with private counselling rooms, camels or bicycles, tents, clients/patient's home, workplaces and pre-existing community facilities e.g. schools, churches or market buildings.(NASCOP, 2008, p.7-8).

Benefits and challenges

Mobile HTC serves hard-to-reach and rural communities where other models of HTC are either not feasible or unavailable. However, these services may require a lot of resources including personnel and equipment and therefore are not cost effective. In rural areas, it may be difficult to prioritise HTC where other serious issues are at stake. Due to the fact that these services are mobile, ensuring quality at temporary sites may not be easy and also follow-up counselling may be difficult. In addition, there is need for broad community mobilisation to ensure uptake of HTC on the date of service delivery (Family Health International, 2005, p. 3-4; NASCOP, 2005, p. 30)

Potential for gender based violence in mobile settings

Structure of setting: temporary sites could offer chances for gender based violence since they only exist for a short period at a certain place and therefore tracking of perpetrators may be difficult.

Safety of clients/counsellors: moonlight HTC is excellent for reaching most at risk groups.. However, since the services are offered at night there is high chance of gender based violence happening. On one hand, perpetrators may rape commercial sex workers with the idea that "they are prostitutes anyway." On the other hand, female counsellors may be victimized by male clients who come drunk to the HTC sites. Furthermore, IDUs or street dwellers may be violent because of the influence of drugs. Another issue is that, victimized clients have no chance of reporting cases of gender based violence after the day of HTC service delivery because the HTC service providers may have already moved to another location.

Quality assurance and control of services: there is a chance of poor quality of services because of the mobile nature of services offered. For example, it may be very difficult to measure how good the HTC services for nomads are since they keep changing their place of residence; therefore personnel in charge of quality assurance may opt not to visit these sites because of high transport costs. In addition, control of HTC services in rural areas may be challenging because of poor infrastructure which makes it difficult for HTC supervisors to visit the sites. Moreover, control of HTC services in rural areas may be overridden by more important issues that are at hand e.g. costs needed for supervision of HTC could instead be used to control of other highly infectious diseases. Since moonlight HTC only caters for a low population, there is a chance that monitoring of this service will not be given a priority. In addition, perpetrators may be hard to find because of the mobile nature of the service.

b) <u>Home-based HIV testing and counselling</u>

As the name suggests, home-based HTC takes place in the homes of the clients or patients. The HTC service provider visits the client/patient at home and offers them the chance to be tested and counselled as individuals, couples or a family. Therefore it is also known as the family-based model. This service can only be given to those who accept to be tested. There are two major ways of providing home-based HTC:

- Door to door – involves counsellors visiting all the homes in a specific geographical area.
- Counsellors only visit the homes of patients in care and treatment (index clients) to offer HTC to their families.

Home-based HTC has been tested in Kenya and was well received by the community. In the pilot areas; Suba and Nandi, the acceptance was above 90% (NASCOP, 2008, p. 8).

Benefits and challenges

Clients and families find this setting more discrete because they don't have to be seen visiting the HTC sites. HTC for couples may lead to increased disclosure about their HIV status and this in turn leads to more social support for one another. Furthermore, the presence of a third party during couple counselling in the home offers the female client protection from domestic violence that may arise after both clients receive the HIV results. Due to access to the whole family, children of HIV-infected and deceased mothers also benefit as they are offered treatment. HIV stigma reduces due to high levels of acceptance and coverage. In addition, this setting is convenient and affordable to some clients, as they don't have to pay for transport to get to HTC sites. Family members have the chance to acquire more knowledge of their HIV status thus leading to improved attitude and behaviour change and emotional support of infected family members. However, this may pose a challenge as parents have to deal with the knowledge of their status first before informing their children or vice versa. Moving from home to home may also be expensive and time consuming for the HTC providers (NASCOP, 2008, p. 8-9; Family Health International, 2005, p. 4).

Potential for gender based violence in home-based settings

Structure of setting: the home of a client provides a more private environment conducive for gender based violence to occur especially if the client is alone at the time of HTC. The home also offers a place where the client and counsellor will not be not be interrupted, thereby placing the security of the client or counsellor at a high risk. In addition, it may be difficult to know whether clients are victimized within their homes since there is no particular fixed site where clients can report cases of violence. Furthermore, if such cases are reported, seeking justice for the victims may be complicated since tracing the perpetrators of gender based violence could become a problem. This can probably be made easier by keeping records of the counsellors who visit particular areas. However, due to the fact that most homes in Kenya, especially in slums and rural areas are not numbered, perpetrators may be hard to find. There is also the possibility that other people

may pose themselves as HBTC providers with the aim of doing harm to people in their own homes.

Safety of clients/counsellors: safety of clients is hard to ensure since HTC happens within the client's own private surrounding. However, protection of clients may be guaranteed by using two counsellors (both male and female) instead of one. Having both a male and female counsellor at the time of HTC offers the female client protection from gender based violence by a male counsellor. The presence of a husband or a male adult in the family at the time of HTC also provides protection to the female client.

Quality assurance and control of services: the presence of both a female and male counsellors at the time of HTC can help to ensure that the services offered are of high quality.

c) Workplace HIV testing and counselling

Productivity and success of many organisations in all sectors of Kenya's economy have been threatened in the past because of HIV related poor health, stigma, absenteeism and death of employees. As a result, overall cost of doing business has increased mainly because of declined productivity, increased demand of expensive health care services for infected employees and cost of replacing staff lost to AIDS (LVCT, 2010). In response to this, employers in the public and private sector offer HTC services to their employees at the workplace itself (on-site) or provide referrals to HTC centers near the workplace. The goal of this approach is to encourage employees at all levels to know their HIV status, to learn how to prevent transmission and acquisition of HIV and to provide link to care and treatment programmes. Because of the principle to consent in the HTC process, workers are not required by their employer to be tested and their HIV status or other personal data may not be disclosed to the employer unless the employee gives permission for this. However, in some organisations, the employer offers financial assistance for the treatment of HIV related symptoms and diseases and therefore it is advisable for the employee to reveal his/her HIV status to the employer (NASCOP, 2008, p. 9).

Benefits and challenges

Offering HTC at the workplace reduces stigma among workers and also lowers the rate of absenteeism and related costs. Therefore it is very cost-effective. Workers' knowledge of their HIV status increases as well as their motivation and commitment to their workplace.

Access to care and treatment for the workers is readily available and in some organisations workers have the chance to receive funding for their treatment. On the other hand, HTC service in this setting is not for all people.

Potential for gender based violence in workplace settings

Structure of setting: workplaces provide less chances for gender based violence since HTC service is mainly provided by the employers.

Safety of clients/counsellors: clients who are the employees and HTC providers know each other as they work at the same place; therefore, chances for gender based violence are minimal because perpetrators stand a chance of loosing their jobs. However, this does not close out the possibility of gender based violence happening. Perpetrators who may have a higher occupational position as their victims may threaten them to keep quite or else loose their jobs.

Quality assurance and control of services: quality assurance is hard to guarantee as these services are only for private companies; therefore whether these companies adhere to the national guidelines of HTC in Kenya cannot be assured

d) Health care setting

In this setting, provider-initiated testing and counselling is usually the model of HTC service offered within the grounds of hospitals, clinics or dispensaries. It is also referred to as When HTC is provided in a medical setting (primarily the public sector) alongside other services such as general in- and out-patient, treatment of tuberculosis (TB), antenatal and sexually transmitted infection (STI) care, then it is termed as an integrated HIV testing and counselling.

The two main approaches to provider-initiated HTC in the integrated setting are diagnostic and routine testing and counselling. Diagnostic testing and counselling is offered to patients who present themselves at the health care centre with clinical symptoms of HIV. It serves to identify HIV positive individuals with the aim of referring them for treatment, care and support. Routine testing and counselling refers to a regular part of standard care for settings such as antenatal, STI and TB clinics. HTC services are offered alongside other medical tests and a client can opt not to be tested if he/she does not want to. HCT within the antenatal care setting cannot be omitted since it is vital to PMTCT interventions (Family Health International, 2005, p. 2). During immunization and check-ups of children

in the paediatric unit, HTC is also offered especially to infants born of HIV infected mothers (NASCOP, 2008, p. 10).

Benefits and challenges

Health care facilities are open to a larger population and thus can offer HTC services to a larger group of potential clients/patients. HTC is provided as part of the general health service and therefore there is a form of "normalization of HIV" in the society. Furthermore, health care facilities are able to directly refer clients/patients to relevant medical services such as TB, antiretroviral therapy, PMTCT, family planning and welfare support. In addition, this setting is associated with low start-up costs that allow for rapid scale-up. Difficulties linked to this setting include shortage of staff due to overload of work as well as competing demands for service provider's time. There is also the chance that health care workers may not have enough time for their HTC clients due to more urgent medical problems. Because of a higher client/patient load, clients/patients may have to wait for too long thus decreasing their motivation to go for testing. Integration of other services may lead to lower quality of HTC services. In addition maintenance of quality may be difficult because of too many clients. Since HTC counsellors not only consist of health care workers, policies of health facilities may not allow non-health care counsellors to work within their premises (Family Health International, 2005, p.2-3; NASCOP 2005, p. 29).

Potential for gender based violence in health care settings

Structure of setting: health facilities may not offer enclosed rooms for HTC due to shortages of rooms especially in governmental hospitals where the number of patients is higher than average. These hospitals may for example only offer segmented areas that have been separated by large curtains, thereby offering no chances for gender based violence. However, such structures go against the principle of confidentiality since people waiting outside can hear what is being said. On the other hand, health care settings that do offer enclosed rooms provide a great chance for gender based violence. Patients who are not only receiving HTC services may be molested or sexually abused during check-up.

Safety of clients/counsellors: as stated above, protection of clients from gender based violence is offered when HTC rooms are not completely enclosed.

Quality assurance and control of services: integration of other services in health facilities may dilute HTC services; therefore reducing the quality. Furthermore, high client and work load may give no room for control of services. Therefore, perpetrators may take

opportunity to violate women because the chances of being caught are low since other health care workers are busy with other patients.

3.3 Gender Based Violence within HIV Testing and Counselling

According to a qualitative study by Hamilton et al., (2008), cases of gender based violence have permeated the safe confines of HTC settings in Kenya. The study was commissioned by Kenyatta National Hospital Review Committee in Kenya and Liverpool School of Tropical Medicine Ethics Committee of the United Kingdom. A total of 31 interviews where conducted in high concentrated HTC clinics in three provinces namely Kisumu, Malindi and Nairobi between November 2004 and April 2005. Participants of the study were HTC service providers including, programme directors, managers, supervisors and counsellors who expressed their perceptions of abuse and described first- and second-hand experiences of abuse within the HTC (Hamilton et al., 2008, p. 392). Results of the study show that abuse within HTC takes place in all the three provinces and that it exists in stand-alone, health facility and mobile settings. Hamilton et al. (2008) found three different types of abuse within HTC rooms, either client to counsellor, counsellor to client or counsellor to counsellor, whereby the woman is the sole victim in all aspects regardless of her professional status.

The study results show that causes of violence are related to gender and power relations as a result of cultural norms, as well as vulnerability of women in either the counsellor or client role within the counselling session. Client-related causes of violence were highlighted to include inability to accept test results and /or challenges of dealing with difficult issues in their lives. On the other hand, service provider related causes of violence were highlighted to include counsellor incompetence, burn-out, stress, lack of training, inadequate support and supervision of counsellors and structural issues like safety of the private counselling rooms. The main forms of abuse experienced by HTC counsellors include use of abusive words, drunkenness, masturbation, physical assault and murder threats e.g. if a client's information is disclosed (Hamilton et al., 2008, p. 392-393). Though not directly mentioned in the article, acts of gender based violence experienced by clients (evident from participants' accounts of abuse) include: rape, sexual assault, physical and sexual abuse, sexual harassment, sexual exploitation and child sexual abuse. The next section looks at the actual acts of gender based violence experienced in the three types of abuse within the HTC in Kenya.

3.3.1 Types of Gender Based Violence in HIV Testing and Counselling

The three types of gender based violence include counsellor to client, client to counsellor and counsellor to counsellor. Within these cases two main types of gender based violence can be observed namely sexual and physical violence which constitute different acts of violence. Following is a description of the actual acts of sexual and physical violence experienced in the HTC room.

e) <u>Counsellor to client</u>

In this case acts of sexual violence experienced include rape, sexual abuse, sexual harassment and child sexual abuse. Counsellors, HTC supervisors and programme managers affirm that rape is one of the acts of violence perpetrated during counselling. The UN High Commissioner for Refugees (UNHCR, 2003) defines rape as

> *"the invasion of any part of the body of the victim or of the perpetrator with a sexual organ, or of the anal or genital opening of the victim with any object or any other part of the body by force, coercion, taking advantage of a coercive environment, or against a person incapable of giving genuine consent."* (p. 16).

Hamilton et al. (2008) gives an account of a woman working at a HTC center in Nairobi who describes a rape ordeal of a client by a counsellor.

> *"One of the most difficult experiences I had is when a client phoned me. She said she'd been raped within one of our counselling rooms…she told me she had come to VCT with a friend and…she was called for her finger prick…and then she was told 'You know there is another test which has to be done with my penis. So then the counsellor put a condom on and he penetrated her and he came…She was so confused now, she was young and she's never been to a VCT before and didn't know whether this was true or not true, but she felt it was wrong."* (p. 393).

In this example, there is abuse of power and trust for the purpose of self satisfaction. The male counsellor took advantage of the vulnerability of the female client who seemed not to be aware of how HIV is tested. Not only did he rape her but he also sexually exploited her. Sexual exploitation means "*any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially, or politically from the sexual exploitation of another"* (IASC, 2009, p. 8)

An account was also given of counsellors from rural health centers that are on the look out for HIV negative girls. It is reported that they pay attention to those who are referred to care and those who aren't, so as to follow the HIV negative girls into the village in the evening and ask them to have sex with them (Hamilton et al., 2008, p. 393). This form of behaviour is an act of sexual harassment as it involves

> *"any unwelcome, usually repeated and unreciprocated sexual advance, unsolicited sexual attention, demand for sexual access or favours, sexual innuendo or other verbal or physical conduct of a sexual nature, display of pornographic material, when it interferes with work, is made a condition of employment or creates an intimidating, hostile or offensive work environment"* (UNHCR, 2003, p. 16).

Children and young girls who visit HTC sites have also become prey to some counsellors. It is reported that some have been molested. This act of violence is termed as child sexual abuse which is referred to as "any act where a child is used for sexual gratification" It involves having any sexual relations or interaction with a child (UNHCR, 2003, p. 16). Sexual abuse of female clients also occurs as female clients are being intimately examined by the counsellors, thus going against the HTC guidelines (Hamilton et al. 2008, p. 393). Sexual abuse is described as "*the actual or threatened physical intrusion of a sexual nature, including inappropriate touching, by force or under unequal or coercive conditions*" (UNHCR, 2003, p. 16).

In an attempt to confirm these acts of violence, female mystery clients[1] were used, of whom one was sexually abused by a male counsellor by being asked to lift her jersey so that he could check if there were lumps on her breast and groins (Hamilton et al., 2008, p. 394).

f) Client to counsellor

In this type of gender based violence, physical and psychological violence have been identified. The act of physical violence present in the HTC is physical assault. Physical assault involves beating, punching, kicking, biting, burning, maiming or killing, with or without weapons and is often accompanied by other forms of sexual and gender-based violence (UNHCR, 2003, p. 17). The study by Hamilton et. al., (2008) gives an account of a male counsellor who he to rescue a female counsellor from being beaten by a male client, who did not want to accept his HIV results. In other instances clients have threatened counsellors with murder if they disclose their information (Hamilton et al.,

[1] **Mystery Clients**: Individuals who pose as clients (source: Hamilton et al., 2008, p. 391)

2008, p. 393). This can be counted as psychological violence since such threats could affect the psychological well being of the female counsellors.

g) Counsellor to counsellor

Sexual abuse was the only act of violence mentioned when it came to violence of a counsellor by a counsellor within HTC. An example of this type of violence is of a female counsellor who was forcefully pinned to the wall by a male counsellor who told her that she had to have sex with him as he was too hot (Hamilton et al., 2008, p. 393-394).

The three types of abuse above highlight the likelihood and present evidences of gender based violence in the privatised room of HTC. They also present a number of human rights violations that need to be addressed thus emphasizing the urgency of protecting the rights of the clients and counsellors within HTC. Though women are reported to be the sole victims, men especially young boys, may also be violated during counselling and therefore there is need for further investigation on this issue. This study was conducted in only three out of eight provinces in Kenya; therefore results of the study are not representative of the whole of Kenya. However, evidences of gender based violence bring to the attention that preventive measures need to be adopted soon so that individuals are not shunned from seeking HTC services. The next section looks at the causes facilitating acts of violence against women in the HTC settings.

3.3.2 Causes of Gender Based Violence in HIV Testing and Counselling

The two root causes of gender based violence identified from the experiences of gender based violence in HTC settings are gender and power relations.

3.3.2.1 Gender Relations

Gender denotes the social characteristics, roles, responsibilities and privileges assigned to men and women in a given culture as well as the opportunities associated with being female or male and the relationships between women/girls and men/boys including the relations between women and those between men (Zaman & Underwood, 2003, p. 1; UNHCR, 2003, p. 11; Office of the Special Adviser on Gender Issues and Advancement on Women (OSAGI, 2010). These characters, roles, opportunities and relationships are constructed within a society and are learned through socialization. They are shaped by

circumstances around them and can change from time to time (OSAGI, 2010). These roles are ascribed to individuals on the basis of their sex (biological differences) and are influenced by family, communities, schools, religious institutions, culture, tradition, history, media, policies and peer groups. Gender roles often reflect local stereotypes, ideologies, values, attitudes, beliefs and practices (Zaman & Underwood, 2003, p. 18). These defined roles and responsibilities may create gender inequalities[2], which favour one group, leading to inequities[3] between women and men (WHO, 2010). The way in which a culture or society shapes rights, responsibilities and identities of women and men in relation to one another is referred to as gender relations (Zaman & Underwood, 2003, p. 18). Issues surrounding gender based violence in HTC settings in Kenya can be traced back to gender relations. The following examples show how the judicial system, gender stereotypes in the society and cultural practices contribute towards shaping gender relations in Kenya.

Amnesty International (AI, 2002) reports of the hidden nature of rape in Kenya, whereby women suffer the ignorance of a system that often protects the perpetrator rather than the rape victims themselves. The report states that in 2001, a divisional police chief from Kiambu freed a church leader who was arrested on suspicion of defilement of a six year old girl with reason that he was a "*married man with children and, therefore, incapable of committing such an offence*" (AI, 2002, p. 16). Five years later, despite the enactment of the first ever Sexual Offences Act in 2006 that tackles all forms of sexual violence by giving stiff sentences to perpetrators of sexual violence, impunity still exists. Njogu and McHardy (2009) show the plight of a woman who tried to seek justice after being raped. In 2009, the rape survivor who won her court case against her attacker found herself back in court (in Nyeri) on an appeal by the convicted perpetrator, who she had already identified and was found guilty on the basis of the evidence that was presented in a lower court. While in high court, Judge Justice Makhandia annulled the conviction on the basis that the victim had not told her mother, teachers or church leaders of her rape ordeal and that it was unlikely that she was raped as she claimed. This he did in spite of the indisputable medical evidence and witness testimonies, as well as her report to the police. Not only was she violated by the rapist but also by the court of "Justice" (Njogu & McHardy, 2009, p. 32).

[2] **Gender equality**: equal conditions for women and men in realizing their human rights as well as in benefiting from social, economical, cultural and political development. (source: UNESCO, 2009)

[3] **Gender equity**: the fair treatment of women or men (source: UNESCO, 2009)

As shown by the two examples above sexual offences against women are dealt with impunity or are disregarded. Furthermore, the element of gender inequality in seeking justice in Kenya is manifested. The prosecution of perpetrators is shown to be ineffective since in Kenyan courts, "*cultural biases are discernible in decisions made by court involving gender-based crimes*" (Orchadson-Mazrui, 2003, p. 156). Such leniency of the state to punish perpetrators of sexual violence is probably a reason as to why perpetrators think they can get away with violating the rights of women in HTC settings.

The second aspect is how gender stereotypes in the society influence gender relations. Often when a woman is sexually abused, she is seen as the one who asked for it. The woman is treated with suspicion and blamed with inciting the perpetrator by behaving or dressing inappropriately (Nowakowska, 2005, p. 122). Such attitudes from the society make people to have the idea that it is the behaviour of the women that leads to sexual violence (Orchadson-Mazrui, 2006, p. 156). Wrong ideologies and stigma of people who visit the HTC settings may contribute to gender based violence in the HTC settings. Taegtmeyer, Kilonzo, Mung'ala, Morgan and Theobald (2005) report that some people in Kenya associate HTC with prostitutes (p. 309). With such ideology, some people may not believe that a female client has been raped by a counsellor for she may be a "prostitute" and therefore given such circumstances perpetrators may find it easy to violate clients. Furthermore, women are often belittled and insulted e.g. during debates on the enactment of the Sexual Offences Act (2006) where a male member of parliament alleges that a section of the bill would criminalize advances towards women by men and says that when women say "no" to such advances, they actually mean "yes" (Mulama, 2010).

The third aspect is how cultural practices shape gender relations. In most Kenyan communities, men are often socialized into believing that they are superior to women. This can be observed during male circumcision rites, whereby constitutions of power and control are implanted in men. During this period, it is the women who are supposed to prepare and serve food for the boys who will later become adult men. According to traditional culture, becoming adult men, gives them the right to order their mothers and sisters about (Orchadson-Mazrui, 2003, p. 162). Contrary to the privileges acquired by men, women learn to be subordinate to men. This example depicts how negative aspects of culture teach inequality between women and men and thus negatively affect women's welfare in the community. If men are taught that they have the right to exercise their superiority over women in their homes, how about when it comes to other women in the society? Likewise, if women learn that they should be inferior to men in their homes, how about to other men in general? Such culturally learned attitudes could also be extended in

the HTC settings, where men would want to apply their superiority while women are subjected to vulnerability because they feel they have no other choice but to comply. This was shown in the above stated type of abuse of counsellor to counsellor, where a female counsellor was raped by her male colleague. According to the story, he pinned her to the wall and told her she had to do it as he was too hot and thus she had to have sex with him (Hamilton et al. 2008, p. 393-394). Normally, one would expect the woman to fight back or scream for help but she didn't. Instead she felt compelled to go through with it even though she didn't want to.

Furthermore, culture hinders the development of women by stopping their education through early marriage. Among the Kuria community, once a girl has been circumcised, she is expected to end her education and get married. The Kuria community view young girls as economic resources and boys as economic investments. The bride price that is paid for the girl is used to educate the girl's siblings. When times get tough, girls are usually traded off for cattle or money and are married off. Such practices deprive women of their right to education and thus affect their understanding of HIV/AIDS. Lack of knowledge can lead to women's vulnerability to gender based violence as they may be very gullible inside the HTC rooms. This was revealed in the example of the woman who was told that she needed to undertake another test that was to be done with the penis.

The International Fund for Agricultural development (IFAD) defines gender relations as "*a complex system of personal and social relations of domination and power through which women and men are socially created and maintained and through which they gain access to power and material resources or are allocated status within society*." Therefore gender relations have everything to do with the distribution of power among women and men in a society.

3.3.2.2 Power Relations

The United Nations High Commissioner for Refugees (2003) describes power as the capacity to make decisions. In regard to making decisions of one's own life, power affirms self-acceptance and self-respect which encourages respect and acceptance of others as equals. However, when it is used to dominate over others, power imposes obligation on, controls, forbids and makes decision about the lives of others (UNHCR, 2003, p. 13). Power relations on the other hand refers to the "*capacity of individual or group to initiate action and determine outcomes which change existing social, political and economic systems and norms, to equalize gender relations"* (Thenya, 2010, slide 16).

Perpetrators of gender based violence often seek to maintain privileges, power and control over others (UNHCR, 2003, p. 21). The occurrence of gender based violence in a health facility as HTC implies that there is abuse of power of the counsellors over the clients and also of men over women. Hamilton et al (2008) observes that it is the imbalance of power bound up within cultural norms that leads to abuse of women in HTC settings (p.392). Likewise, Thege, identifies that it is the power exacted in any sexual interaction that determines when, how and with whom sex takes place and that sexual abuse happens as a result of unequal power balance in gender relations that often favour men. In addition, she also mentions that it is the social norms that give men more power and freedom, who then use this to control women (Thege, p. 5-6). Following are examples of power imbalances caused by social and cultural norms in Kenya that may be extended within the HTC settings.

Kenya is a patriarchal[4] society where the element of masculinity is deeply engraved in the languages and cultural practices of Kenya's communities. For instance, the vocabulary on gender in the Kikuyu community reveals that the word for man "*murume-murume*" comes from the word "*urume*", which means exceedingly courageous. On the contrary, the word for woman, "*mutumia*", originates from the word "*tumia*", which means to "shut up" or condone. Therefore, men from the Kikuyu community see themselves as the dominant sex and the women as simply objects that exist for their use (Center for Rights, Education and Awareness, p. 6). This shows how men in some Kenyan communities are brought up to think of women not only as subordinates but also as their instruments.

When it comes to cultural practices, women are often downgraded to a second class status in the society, thereby not only discriminating them but also violating their human rights. Being a patriarchal society, the husband in Kenya is the head of the home and the woman often has little influence over decisions affecting her (AI, 2002, p. 12). Customary laws governing land and property ownership are obstacles to the welfare of women in Kenya. In 2004, women owned only 1% of land titles. In some communities women have no control over property even after the man dies. When the man dies, the woman loses her property to the man's relatives because there is no law governing the equal division of property. The law only protects title deed holders or any person in whose name property is registered but in most cases these properties are registered under the names of men

[4] **Patriarchal**: means 'Rule of father' and refers to the male dominated social relations, ownership and control of power at many levels in the society (Thenya, 2010, slide 16).

(IEA, 2008, p. 44-45). The nature of such patriarchal ideology in Kenya makes women very vulnerable to gender based violence as they are forced to economically depend on men and husbands. A patriarchal system produces social structures of inequality when it comes to social resources. Therefore a woman in such a society (usually in the rural areas) may not be in a position to defend herself in case of violence since she can not afford a lawyer. Perpetrators of gender based violence in HTC may take advantage of this with the consciousness that such women will not file a case against them.

Some social and cultural practices deny women the opportunity to participate in certain systems. Many Kenyan cultures still define the place of a woman as being in the kitchen and raising children as part of their gender role. As a result, men find it hard to understand and accept women who are at the same level as them (IEA, 2008, p. 42).Consequently, women are often locked out of political representation, decision-making and coordination process. When it comes to women's political representation, a minor proportion of women is represented in senior and middle level policy making and implementation processes. For example, in 2006 out of 34 ministers in Kenya, only 2 were female and out of 40 assistant ministers only 6 were female. This can be attributed to negative stereotypes and socio-cultural attitudes within strong patriarchal systems that work against women, the lack of society to accommodate women in leadership positions, low levels of education among women in some communities and the lack of financial means to sustain competitive campaigns. Lack of decision making power has also been witnessed in IDP camps where women are not included in decision-making and coordination processes and therefore their needs are not addressed (Myrum, 2008, p. II-III). When women are not offered the same opportunity to participate in political issues as well as in the community, issues affecting them e.g. gender based violence are not addressed.

Male control also pervades matters of sexual relations. For example, the Kenyan media often portrays men carrying condoms in adverts, showing the control of men over sexual issues but if a woman is seen carrying condoms; she is viewed as promiscuous (Orchadson-Mazrui, 2003, p. 157). Such ideologies that are instilled through the media could enhance the already existing patriarchal way of thinking of men and thus result in gender based violence.

As shown above, society's attitudes and practices of gender inequalities when it comes to decision making, land and property ownership and access to education have placed women in subordinate positions in relation to men. Issues such as lack of social and economical value for women and women's work as well as gender roles that are accepted

in society, reinforce the idea that men have decision-making power and control over women. Through acts of gender based violence, perpetrators seek to obtain power and control over their victims.

3.4 Summary

In short, considering the high rates of HIV infection in Kenya (7.4% prevalence rate among adults aged 15-49 years, KAIS, 2007), HTC is a vital tool in combating the spread of the disease as it gives the public an opportunity to know their status so that they can protect themselves from acquiring or transmitting the virus. The two major types of HTC service in Kenya are; client-initiated voluntary counselling and testing which is based on the client's own request to be tested of HIV and provider-initiated HIV testing and counselling (PITC) which is based upon the provision of HTC that is initiated by a health care facility. These services are provided for in stand-alone sites, mobile, home-based, workplace and in health care settings. Gender based violence can take place in all the settings, however workplace settings offer little chances since HTC services are offered within the premises of a company or organization. In the stand-alone sites, assurance of quality of service may be difficult in since they are run by private organizations. In addition high travel costs may hinder HTC supervisors from monitoring mobile settings. Furthermore, home-based settings pose a danger to women who are alone at home at the time of HTC. In health facilities, integration of other services ass well as high work load because of many patient/clients many leave no room for supervision of HTC services and thus perpetrators may take opportunity of this.

Research shows that gender based violence happens within HTC and affects only women and girls. It is either perpetrated by counsellor to client, client to counsellor or counsellor to counsellor. Acts of gender based violence happening within the counselling room include rape, sexual and physical abuse, sexual harassment, sexual exploitation and child sexual abuse. The causes of gender based violence are rooted within gender and power relations bound up within cultural and social norms. The way culture and society teach superiority among men and submissiveness among women and also how identities of men are shown to have control over women influence how men and women think and behave inside the HTC room. Evidences of gender based violence highlight the need to address this issue from a human rights point of view. The next chapter seeks to identify which rights are being violated within the HTC.

4. Analysis of Gender Based Violence in HTC from Human Rights Perspective

Human rights are defined as the fundamental rights which enable individuals to live a life of dignity and to develop their full potential as human beings regardless of place of residence, sex, national or ethnic origin, colour, religion, language, or any other status (Office of the High Commissioner for Human Rights (OHCHR), 2010) They are rights held by all persons simply because they are human beings. These rights are

- *inalienable*: one cannot lose these rights any more than one can cease being human,
- *indivisible*: one cannot be denied a right because it is less important or non-essential and
- *interdependent*: all human rights are a part of a complementary framework (Flowers, n.d.) e.g. a woman's right to health is affected by her right to equality, education and information.

Human rights consist of civil and political rights, such as the right to life, liberty and freedom of expression; and social, cultural and economic rights including the right to participate in culture, the right to receive education, the right to work and the rights to health. On 10th December 1948, the United Nations General Assembly adopted the Universal Declaration of Human Rights (UDHR) which states in Article 2 that

> *"All human beings are born free and equal in dignity and rights" (Article 1) and that "Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status" (Article 2, Gierycz, 2002, p. 31).*

Human rights are often expressed and upheld by international and national covenants, laws and treaties, as well as customary international law. These international human rights obligate governments to protect and promote the human rights and fundamental freedoms of all individuals. Human rights conventions are established internationally when a sufficient number of countries make an agreement. However, they only become a part of the national legal system when a country ratifies them into its laws and enforces them domestically. On the other hand, human rights declarations are basically passed by the United Nations General Assembly and are gradually integrated into the customary international law. However, countries are not required to ratify them (Merry, 2009, p. 83).

Both human rights conventions and declarations have contributed in defining gender based violence. Their contributions to the definition of gender based violence will be discussed later in this chapter. To begin with, the importance of a human rights perspective in relation to gender based violence is discussed as follows.

4.1 Importance of a Human Rights Perspective

In the efforts to define and combat gender based violence, an understanding of human rights law is important. According to Merry (2009), human rights are in themselves a system of quasi law as they consist of features that are law like but lack the enforcement power compared to state law (p. 82).

Jacobs (2003) states that a human rights perspective brings into focus a government's obligation to ensure the protection of the rights of its people by providing a clear framework that gives guidance on what is expected of them and serves as an instrument to bring about change through the international law (p. 17-18). Gender based violence is usually perpetrated by individuals or groups of people, yet activists argue that it is the state that has failed to protect women and that this in itself is a human rights violation (Merry, 2001, p. 86-87). Merry (2009) argues that although governments are not required to prevent all criminal activity against their people, their failure to prosecute crime against one group of people with the same energy as when they prosecute other crimes against another group, makes them guilty of discrimination. She further articulates that when states fail to protect their members from violence in a discriminatory way, they violate their responsibility towards them (Merry, 2009, p. 85).

A human rights perspective brings to light that it is domination and power exerted by men over women that leads to violence. This view was exerted by the Declaration on the Elimination of Violence against Women (1993) that states that gender violence is rooted to historically unequal power relations between men and women that lead to the domination of men over women (Gierycz, 2002, p. 45). Furthermore, it reveals the gender specific forms of violence that women face as a result of social and economical inequality that affect their status, as opposed to men.

Consequently it explains the way women are targets of specific forms of violence (especially sexual violence), not just because of their gender but also because of their race, sexuality, ethnicity, class or even their status as refugees or as part of an indigenous group and also because of a disability. A human rights perspective also highlights the

continuity of violence against women that is observed through abusive husbands and partners, rapists, sexual harassers and exploiters among others, who assert their power over women so as to shame them, inflict fear and control their sexuality, deny them access to public resources and maintain dominance over them (Jacob, 2003, p. 18).

By using a human rights perspective, activists, or local groups of people can apply pressure to states to comply with human rights standards by appealing to international NGOs who then mobilize political support within a dominant country so as to expose points of human rights violation and to condemn and put pressure on the violating states (Merry, 2009, p.83). Through this violating states can be pushed to meet the required terms relating to human rights. Merry (2009) further points out that human rights declaration and conventions can contribute to cultural change as they express new norms that are produced through a process of international deliberations that resulted in a general agreement. Through communication networks such as the internet, these international documents are disseminated thus bringing global attention to human rights violations. Though communication networks and other mobilization of public opinion are not law, they act as motivators for local institutions who are concerned about their public image on the international scene. Therefore mobilization of public opinion through reports, information, media etc. helps to strengthen the quasi-legal system of human rights (Merry, 2009, p. 83).

Gender based violence is understood to be a consequence of gender order established in a society where hierarchy and power relations characterize the relations between women and men. In so doing, gender based violence denies women the right to fully enjoy human rights as stated in the Universal Declaration of Human Rights. This therefore implies that a human rights perspective requires that gender based violence be viewed not only in terms of the consequences attached to it but also in terms of the root causes leading to it; that is gender and power relations in the case of HTC in Kenya. The fundamentals of human rights provide women the chance to advance their efforts in demanding for equal rights and also to fight against violence. The right to be free from gender based violence is one of the recent rights added to the fundamental human rights. Following is a brief history of how gender based violence came to be recognized as a human rights violation.

4.2 Recognition of Gender Based Violence as a Human Rights Violation

The historical development of the concept of human rights led to the formulation of legal standards that have been set out in the International Bill of Human Rights. This entails numerous human rights and freedoms related to all spheres of life; political, economical, social, civil, cultural and personal. Examples of these rights are the right to life, the right to freedom, the right to education, the right to health and the right to work. However, these general international human rights instruments do not directly refer to the human rights of women but instead set standards for the human rights protection of everyone (Gierycz, 2002, p. 31).

Despite the broad catalogue of international human rights, women do not enjoy the full and equal human rights and freedoms and suffer gender discrimination in all spheres of life (Gierycz, 2002, p. 33). Although the bill of rights contained universal standards of human rights that addressed equal protection against violence to all, many forms of violence against women were considered private, domestic or culturally and socially justified because "the woman deserved it" e.g. in the case of honour killings. Acts of violence against women such as battering, rape and physical assault were defined as "private disputes" and therefore treated differently from criminal offences or torture, simply because the victim was female (Gierycz, 2002, p. 44).

The Global Campaign for Women's Rights

The issue of gender violence took a drastic turn over when activists from around the world together with NGOs and UN agencies came together to campaign for the rights of women (Merry, 2009, p. 78). This led to the formation of the Global Campaign for Women's Human Rights that was facilitated by a series of global conferences on women between 1975 and 1995 (Jacobs, 2003, p. 18; Merry, 2009, p.78). The first two women' conferences in Mexico City (1975) and in Copenhagen (1980) did not place violence against women at the fore front. However, in 1985 the Nairobi Forward-looking Strategies for the advancement of women, formulated during the Nairobi conference identified violence against women as a basic strategy for addressing the issue of peace (Merry, 2001, p. 87).

In 1979, a breakthrough was achieved when the international community acknowledged the vast range of gender inequalities and discriminations against women. During this year, the Convention on the Elimination of Discrimination against Women (CEDAW) was adopted by the United Nations General Assembly at the Vienna World Conference on

Human Rights. CEDAW (1979) constitutes the central and most comprehensive bill of human rights that aims to specifically promote and protect women's fundamental human rights (Gierycz, 2002, p. 34; COVAW, 2009, p. 5).). For example in article 16, the convention points out the right to equality in marriage and family where most acts of violence against women take place (Gierycz, 2002, p. 39). However, CEDAW (1979) did not provide any specific instruments on violence against women. In 1990, the United Nations Economic and Social Council adopted a resolution recommended by the Commission on the Status of Women (CSW) that identifies violence against women as a cause of unequal status in the society. Additionally, the resolution recommends states to take action in preventing and controlling gender based violence in the family, workplace and society and to establish penalties for them (Merry, 2001, p. 87).

In 1992, the General Recommendation No. 19 on VAW by CEDAW (1993) was adopted. This defined gender based violence as a form of discrimination placing it within the rubric of human rights and fundamental freedoms and clearly pointed out that states are compelled to eliminate violence perpetrated by the public authorities and private persons (Merry, 2009, p. 78-79). Recommendation No. 19 defines gender based violence as "… *violence directed against a woman because she is a woman or which affects a woman disproportionately. It includes physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty*" (United Nations Special Rapporteur on Violence against Women, 2009, p. 4)

The issue of gender based violence became even more significant during the UN Conference on Human Rights in Vienna in 1993. Women NGOs brought great attention to gender based violence by gathering 300,000 signatures from 123 countries, thus placing it on the central agenda. The product of this conference is the Vienna Declaration and Programme of Action (1993) that formally recognizes the human rights of women and of the girl child as inalienable, integral and indivisible part of universal human rights (Merry, 2009, p. 79). In its statement, "*Women's rights are human rights*," the Vienne Declaration and Programme of Action shifted women's demands from being unimportant to being recognized as the rightful entitlements of women all over the world and also highlighted the relation of gender and human rights violations. In addition to examining gender based violence, the Global Campaign has brought the international community to also look at the fact that when women face violations similar to those experienced by men, the violations are taken less seriously and thus are less condemned and penalized (Jacobs, 2003, p. 19).

Another important international Instrument that seeks to protect women from violence is the Declaration on the Elimination of Violence against Women (DEVAW) that was adopted by the United Nations General Assembly on 20th December 1993 (Gierycz, 2002, p. 44). It is in DEVAW that a comprehensive definition of violence against women was established. This is the definition that was given in chapter 2.

> ‘‘*any act of gender-based 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 deprivations of liberty, whether occurring in public or private life."* (United Nations Special Rapporteur on Violence against Women, 2009, p. 4)

DEVAW further encompasses the scope of private and public to include violence occurring in the family, the community and violence perpetrated or condoned by the state. In Article 2 it states that VAW shall be understood to include but not limited to the following:

- *"Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;*
- *Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;*
- *Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs."* (United Nations Special Rapporteur on Violence against Women, 2009, p. 4).

In addition, DEVAW (1993) identifies the root cause of violence against women as the historical expression of unequal power relations between men and women that forces women into a subordinate position as compared with men and leads to domination and discrimination of women by men. The connection of gender based violence to unequal power relations to some extent reveals why it was not recognized as a human rights issue, as a public matter and as a criminal offence for many years (Gierycz, 2002, p. 45). However, DEVAW (1993) is a declaration and not a convention and therefore does not posses any legal binding force for state parties but rather has a moral strength and commitment for countries of the UN to develop measures of combating gender based violence (COVAW, 2009, p.5-6).

In subsequent UN conferences, women continued to lobby for a wider recognition of women's human rights. In 1995, the Fourth World Conference on Women took place in Beijing that established a gender approach as a new concept in the achievement of equality (Gierycz, 2002, p. 20). The Beijing Conference produced a document known as Platform for Action (1995) whose definition of violence against women is the same as in DEVAW. It includes gender based violence happening in the family, community or perpetrated by the state. Contrarily to DEVAW (1993) it goes on further to include acts of violence and sexual abuse during armed conflict, forced sterilization and abortion and female infanticide. It states that

> *"Violence against women both violates and impairs or nullifies the enjoyment by women of their human rights and fundamental freedoms. The long-standing failure to protect and promote those rights and freedoms in the case of violence against women is a matter of concern to all states and should be addressed"* (UN Division on the Advancement on Women, 2009, D [112]).

On 11th July 2003, the African Union (AU) adopted the Protocol to the African Charter for Human and People's Rights on the Rights of Women in Africa, commonly known as the Maputo Protocol. This Protocol supplements the African Charter on Human and People's Rights (ACHPR) that was adopted in June 1981 in Nairobi, Kenya. The ACHPR (1981) does not specifically address the problems and needs encountered by women in Africa as well as the various international and regional instruments on the rights of women. This therefore led to the adoption of the Maputo Protocol (2003) which acknowledges that though African states have ratified the African Charter on Human and People's rights as well as the International Bill of Rights (UDHR [1948], CCPR [1966] and CESCR [1966]) and CEDAW (1979), gender issues are still missing in political agendas. The Protocol acts as a defender for the rights of women and girls in Africa and advocates for gender equality. It represents a violation of fundamental rights and freedoms of women that exempt them from enjoying their rights, thus hindering the achievement of equality, development and peace (COVAW, 2009, p. 6). Here VAW is defined as

> *"… all acts perpetrated against women which cause or could cause them physical, sexual, psychological, and economic harm, including the threat to take such acts; or to undertake the imposition of arbitrary restrictions on or deprivation of fundamental freedoms in private or public life in peace time and during situations of armed conflict or of war"* (ACHPR, 2010, Article 1).

State parties to the above stated international conventions, treaties and charters are obliged to sign and ratify them, as well as domesticate them into their own laws. In addition, these countries are required to report on the status of the implementation to committees that are assigned to assess the status of implementation on the instruments (COVAW, 2009, p.10).

The Kenyan context

Kenya recognizes gender based violence as a human rights violation and has therefore signed and ratified various international as well as regional human rights instruments that deal with VAW. In 1999, the Attorney General acknowledged that

> *"[v]iolence against women pervades all social and ethnic groups. It is a societal crisis that requires concerted action to stem its scourge... Culture does influence the relationship between the various groups in society and...some cultural practices, beliefs and traditions have had the tendency to relegate women to a second class status in society thereby not only violating their rights as human beings [but] leading to discrimination against women. Some...customs and cultural practices have found their way not only into law but...[are used] as justification for violence against women."* (AI, 2002, p. 1-2).

At the international level, Kenya is state party to a number of covenants and treaties that address equal rights for women and violence against women. By ratifying international covenants and treaties, Kenya is obliged to harmonize domestic laws with the international human rights, implement the rights guaranteed by the covenant and treaties and to regularly report on the progress to the UN treaty bodies. Table 1 below shows the various international human rights treaties and covenants relating to VAW that have been signed and ratified by the Kenya government.

International Human Rights Instruments and Date of Adoption	Entry into Force	Signed by Kenya	Date of Ratification in Kenya
International Covenant on Civil and Political Rights (16. 12. 1966)	23. 03. 1976	-	01. 05. 1972 (OHCHR)
International Covenant on Economic, Social and Cultural Rights (16. 12. 1966)	03. 01. 1976	-	01. 05. 1972 (OHCHR)
Convention on the Elimination of All Forms of Discrimination against Women (18. 12. 1979)	03.12. 1981	1984 (COVAW, 2009)	09. 03. 1984 (OHCHR)
Convention against Torture, Cruel or Inhuman Degrading Treatment or Punishment (10. 12. 1984)	26. 06.1987		21. 02. 1997 (OHCHR)
Convention on the Rights of a Child (20. 11. 1989)	02. 09. 1990	1989 (COVAW, 2009)	30. 07. 1990 (OHCHR)

UN Security Council Resolution 1325 on Women, Peace and Security (31. 10. 2000)		2000 (COVAW, 2009)	
Beijing Platform for Action (1995)		1995 (COVAW, 2009)	

Table 1: International Human Rights Instruments that are Signed and Ratified by Kenya

Source: UNHCR (2010) and COVAW (2009, p. 36)

Though Kenya has ratified CEDAW (1993), certain aspects of the old Kenyan Constitution mismatched the provisions of CEDAW. For example, the old Constitution excluded "sex" as ground for discrimination. However, the new Constitution that was recently ratified on the 5th August 2010 correlates to CEDAW's definition of discrimination (see Table 2 below). CEDAW (1979) defines discrimination as "… *any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field." (*OHCHR; 2007, Article 1). In addition, it states in Article 2 [a] that member states should undertake to embody the principal of equality in their national Constitution (OHCHR, 2007).

Constitution of Kenya	Definition of Discrimination
Old (section 83 [3]) Revised version (2001) (1998)	*"…"discriminatory" means affording different treatment to different persons attributable wholly or mainly to their respective descriptions by race, tribe, place of origin or residence or other local connection, political opinions, colour, creed or sex whereby persons of one such description are subjected to disabilities or restrictions to which persons of another such description are not made subject or are accorded privileges or advantages which are not accorded to persons of another such description."*
New (section 27 [4]) Proposed Constitution (06. 05. 2010	"*The State shall not discriminate directly or indirectly against any person on any ground, including race, sex, pregnancy, marital status, health status, ethnic or social origin, colour, age, disability, religion, conscience, belief, culture, dress, language or birth*."

Table 2: Definition of Discrimination in Old and New Constitution of Kenya

Source: UNHCR (2010) & Republic of Kenya (2010)

With regard to the reporting requirement of CEDAW (1979), Kenya has submitted its yearly reports late and has also combined reports of several years into one. For example, the first CEDAW report that was due in 1985 was submitted on the 4th December 1990, while the fifth and sixth reports were combined and submitted in January 2003 (COVAW,

2009, p. 19). The Kenya government has also been slow in domesticating the provisions of the Beijing Platform for Action (COVAW, 2009, p. 21).

At the regional level, Kenya is a member to the African Charter on Human and People's Rights that was adopted in June 1981 in Nairobi, Kenya. The Charter provides that "*each person is equal before the law and must be protected equally by the law*" (Article 3). In addition, in Article 5, it guarantees every person "*the right to the respect of the dignity inherent in a human being*" and prohibits torture, cruel, inhuman or degrading punishment or treatment (ACHPR, 2010). Kenya is also a party to the other regional treaties as shown in table 3 below.

Regional Human Rights Instruments and Date of Adoption	Entry into Force	Signed by Kenya	Date of Ratification/Accession in Kenya
African Charter on Human and People's Rights (27. 06 1981)	21. 10 1986 (AU)	-	23. 01. 1992 (AU)
Protocol to the African Charter on Human and People's rights of Women in Africa (11. 07. 2003)	25. 11 2005 (AU)	17. 12 2003 (AU)	Not ratified (AU)
African Charter on the Rights and Welfare of Children (July 1990)	29. 11. 1999 (AU)	-	25. 07. 2000 (AU)
African Platform for Action		Signed in 1994 (COVAW, 2009)	

Table 3: Regional Human Rights Instruments that are Signed and Ratified by Kenya

Source: African Union & COVAW (2009, p. 36)

According to COVAW (2009), Kenya has not yet ratified any of the protocols of the African Charter on Human and People's rights on the Rights of Women in Africa (p. 11). In view of Article 4.2 of the Protocol on the right to life, integrity and dignity, prevention of gender based violence in Kenya has not been prioritized (COVAW, 2009, p. 12). Although bills that would protect women against gender related injustices were introduced in Kenya e.g. the Domestic Violence Bill (Family Protection Bill), Equal Opportunities Bill, Marriage Bill and the Matrimonial Property Bill, they still have not been passed. Some of them await enactment since 2001 (Njogu & McHardy, 2009, p.34).

So far, the major achievement attained in combating gender based violence in Kenya has been the enactment of the Sexual Offences Act (2006) which gives stiff sentences to perpetrators of sexual violence. Though this is a great milestone, there exists some controversy. Section 38 of this Act states that

> *"Any person who makes false allegations against another person to the effect that the person has committed an offence under this Act is guilty of an offence and shall be liable to punishment equal to that for the offence complained of"* (FIDA, 2007, p. 30)

This section could hinder a survivor of gender based violence to report the case because of fear that he/she may be punished if the case fails. According to Njogu & McHardy (2009), Kenya thus becomes the only country worldwide, where a victim of rape could end up being imprisoned by a court of justice for accusing the perpetrator (p.33-34).

With regard to the international and regional human rights instruments stated above, Kenya still has to domesticate human rights that protect women from gender based violence. The Kenyan government still recognizes domestic violence as a private affair. For example, marital rape is not recognised as a criminal offence because the act of marriage is considered consent to sexual intercourse (AI, 2002, p. 8). Furthermore, in cases of rape, women are often ridiculed and verbally abused by the police leading to low reporting levels of violence by the victims. There is also absence of an effective system to investigate allegations of sexual violence and rape in Kenya (Amnesty International, 2002 p. 16). Treaties that have been signed or ratified by Kenya have either been slowly or not at all domesticated. For example, before the 5th of August 2010, Kenyan women had no equal rights to land ownership, matrimonial property and were not protected from traditional practices that violated their economic, social and cultural rights.

Kenya's failure in the past to promote gender equality through legislation has been now been resolved through the ratification of the new Constitution on the 5th of August 2010. The new law that came into force on the 21st August 2010 promotes and protects the rights of women in Kenya (Kagwe, 2010). Section 27 (3) of the constitution states that "*Women and men have the right to equal treatment, including the right to equal opportunities in political, economic, cultural and social spheres*." With reference to violence it states in Section 29 that "*Every person has the right to freedom and security of the person, which includes the right not to be … [c] subjected to any form of violence from either public or private sources …*" Women can now enjoy equal rights of land ownership as provided for in Section 40, "… *every person has the right, either individually or in*

association with others to acquire and own property …" Furthermore, equal rights of matrimonial property have also been given in Section 45 [3]. However, Implementation of these rights is yet to be witnessed by women in Kenya (Republic of Kenya, 2010).

Gender based violence took a long journey to being recognized globally. The previously stated definition of gender based violence in chapter 2 is that which has been given in DEVAW (1993). It includes physical, sexual and psychological harm to women in the public and private life. Gender based violence in HTC settings can therefore be defined as violence occurring within the community and also that which is perpetrated by the state due to Kenya's failure to domestic human rights instruments that address VAW.

4.3 Violation of Human Rights within HTC in Kenya

A Look at gender based violence from a human rights perspective allows one to see the various issues presented in HTC in a broader context. This chapter identifies the violations of human rights within HTC in Kenya.

4.3.1 The Right to Dignity, Liberty and Security of Person

Female clients' and counsellors' right to dignity, liberty and security as defined under Article 1 and 3 of the United Nations Declaration of Human Rights as well as in other international laws are violated by male counsellors and clients. Every client in the HTC has the right to be treated ethically and with respect. Acts of gender based violence such as rape, sexual abuse, child sexual abuse and sexual exploitation often take place in coercive conditions where the victim is forced or threatened to act in way that he is not willing to. This takes therefore takes away the freedom of the victim to refuse and or defend himself/herself from the perpetrator/perpetrators.

Female counsellors are threatened with murder by male clients if they reveal the clients information, thus posing a danger to their security. This poses the question of how safe the female counsellors are within the counselling rooms. A murder threat is a serious issue. If the client's information comes out through another way, does this mean that the client will still hold the female counsellor responsible and murder her? It should be the duty of the HTC officials to ensure that female counsellors are not subjected to violence of any kind within the HTC rooms. Such threats should be taken seriously so as to secure

the life of the counsellors and these clients should be dealt with immediately, most preferably by male counsellors.

Female clients are stripped of their human dignity as some are intimately examined, children are molested and women are raped by male counsellors. Women and children visiting the HTC sites for the first time may be more vulnerable to gender based violence as the perpetrators could easily pose themselves as gynaecologists and deceive them of intimate check-ups or of "other tests" that need to be undertaken. This was evidenced in the case of the young woman who was deceived of another test. In her case, one could assume that she did not attend school so as to realize that a HIV is not tested through penetration and that she probably had no idea about HIV/AIDS, which therefore made her very vulnerable to sexual violence.

Children who are molested within the HTC sites are also robed of the dignity, liberty as well as security. To children, counsellors may seem to be like doctors or nurses and they may put their trust in them without much consideration. They may not understand what exactly is happening to them and therefore their human rights should be highly protected. Confidentiality is one of the principles of HTC. However, when it comes to children the issue of protection should be addressed as children can be highly vulnerable to gender based violence. The International Covenant on Economic, Social and cultural rights (CESCR, 1966) emphasizes in Article 10 (3) that "*special measures of protection and assistance should be taken on behalf of all children and young persons without any discrimination for reasons of parentage or other conditions."* Whether the children are counselled individually or not is not mentioned. It would be in the best interest of the children when they are counselled only by trained counsellors whose role is to specifically counsel children and not just any counsellor at the HTC site. HTC sites should take responsibility and accountability of children under the age of 18 years so as to ensure that their human rights are not violated.

Although gender based violence in HTC is perpetrated by private individuals, the state should take action and create safe conditions for clients and counsellors to realize their human rights and also punish the perpetrators of gender based violence.

4.3.2 The Right to be Free from Sexual Violence

Female clients are raped or molested by counsellors in whom they place their trust and reliance on. In addition, sexual violence occurs in the very rooms where they should feel safe and should be able to receive advice and assistance. Furthermore, some women who are HIV negative are sexually harassed by male counsellors, who follow them into the village in the evening to ask for sexual favours. Female counsellors on the other hand are sexually abused by male counsellors who feel they can exert their power over their female colleagues so as to sexually gratify themselves. Sexual violence in the HTC settings infringes upon the fundamental human rights of female clients and counsellors as provided for in many international human rights instruments.

The Universal Declaration of Human Rights (1948) states that all humans are born free and equal in dignity and rights and therefore no should be subjected to torture or to cruel, inhuman or degrading treatment (UN, Article 1 & 5). The General Recommendation No.19 on violence against women of CEDAW (1992) identifies gender based violence as a form of discrimination against women because they are women (UN Division for the Advancement of Women, 2009). In addition, the Maputo Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2003) states the obligation of member states to adopt measures and enact laws that protect women from all forms of sexual violence whether they take place in the private of public sphere (ACPHR, Article 3 & 4). Moreover, the Convention against Torture and other Cruel, Inhuman, or Degrading Treatment or Punishment (1984) defines torture as *"… any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as …intimidating or coercing him" (Article 1). In addition it calls on states parties to prevent any cruel, inhuman or degrading treatment of punishment* (OHCHR, 2007 Article 1 & 16). Sexual violence involves the use of force or coercion and is therefore an act of torture. The International Covenant on Economic, Social and Cultural rights (CESCR, 1966) obliges member states to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights. (OHCHR, 2007, Article 3), whereas the International Covenant on Civil and Political rights (1966) gives reference to no subjection of torture, cruel, inhuman or degrading treatment (OHCHR, 2007, Article 7). Children have also been given protection under the Convention of the Rights of a Child (1989) that obligates states to take legislative, administrative, social and educational step to protect children from all physical or mental violence including sexual abuse (OHCHR, 2007, Article 19 [1]).

Other treaties include DEVAW (1993) which address violence against women in Article1-4, the Vienna Declaration and Programme of Action (1993) that was formed during the world conference on Human rights. In Article 18, it states that sexual harassment and exploitation are incompatible with the dignity and worth of the human being. In Article 38, it stresses the importance to eliminate gender violence in public and private life (OHCHR, 2000). Beijing Platform for Action explains that VAW is an obstacle to the achievement of the objectives of equality, development and peace. (UN Division for the advancement of Women, 2009, Para. 112). Finally is the Copenhagen Declaration (1995) that calls on state parties to enact and enforce laws, implement policies to fight and eliminate all forms of discrimination and VAW in accordance to the international instruments and declarations (UN, Commitment 5 [h]).

4.3.3 The Right to the Highest Attainable Standard of Health

The World Health Organisation defines health as the state of complete physical, mental and social well-being and not just merely the absence of disease or infirmity. The right to health is one of the basic rights of every human being and it entails the enjoyment of the highest attainable standard of health without distinction of race, religion, political belief, economic or social condition (WHO, 2006, p. 1). Sexual and physical violence of female clients and counsellors in the HTC robs them of their physical, psychological and social well-being thus violating their right to enjoy the highest possible standard of health.

The right to health is an inclusive right as it not only includes access to health care but also the determinants of health such as access to healthy working and environmental conditions and health related education and information among others (OHCHR & WHO, 2008, p. 3). This therefore means that clients in the HTC sites have a right to be given information on sexual and reproductive health. Sexual abuse of female counsellors on the other hand deprives them their right to healthy working conditions.

The right to health contains freedoms including the right to be free from non-consensual medical treatment such as medical experiments and research and to be free from torture and other cruel, inhuman or degrading treatment (OHCHR & WHO 2008, p. 3). In the case of the young woman who was deceived of “another HIV-test with the penis,” the male counsellor not only violated her right to be free from sexual abuse but also her right to be free from non-consensual testing. During the HTC process, a client first has to be informed before being tested. This is in line with the UNAIDS/WHO policy that states

informed consent as one of the underlying principles of HTC (UNAIDS, 2004, p. 1). According to the narrative, the young woman was neither informed of a second test nor did she give consent to it. The right to health also consists of entitlements such as the right to maternal, child and reproductive health as well as the right to prevention, treatment and control of diseases. HTC is an entry point to prevention, treatment and care of HIV/AIDS but certainly not to rape, sexual abuse, sexual harassment and child sexual abuse.

Sexual violence is a cruel and degrading act that not only affects the physical health of the victims but also their psychological and social well being. Consequences of sexual violence include pregnancy, gynaecological complications, sexually transmitted diseases, depression and post-traumatic stress disorder, suicidal behaviour and emotional disturbance, and social ostracization e.g. through gender stereotypes that make the victim responsible for "provoking" the crime. Furthermore, since HIV positive counsellors are allowed to work at HTC settings, there is the possibility that HIV positive perpetrators of gender based violence in HTC could be transmitting HIV to their clients. The environment that should serve as an educational center where individuals learn of how to protect themselves and their partners from HIV could end up becoming the place where their health is made worse than before.

The right to health requires that the services, facilities and goods are available, accessible, acceptable and of good quality (OHCHR & WHO, 2008 p. 4) According to Hamilton et al. (2008), HTC service providers related the causes of abuse on the side of counsellors as incompetency, lack of training and inadequate support and supervision (p. 392-393). This raises concerns of the quality of HTC services and also of the security of clients in the HTC sites. Furthermore, when clients are raped in the HTC rooms, they are denied their right to access health services because gender based violence installs fear in them thereby affecting their future visits to other similar HTC settings. Victims may spread word of such acts of violence in their communities, leading to low rates of HTC visits. Pregnant women who hear of such acts of violence may avoid PMTCT services, thereby placing their unborn babies in danger of acquiring HIV in case the mothers are HIV positive.

Finally, the right to health means that the health services should have respect to medical ethics and also be gender sensitive (OHCHR & WHO, 2008, p. 4). Perpetrators of sexual violence in the HTC sites abuse the ethics of counselling. Instead of being informed and advised on how to prevent acquisition of HIV/AIDS or on behaviour change, female clients

are morally degraded. This behaviour might give HTC services a bad reputation thus scaring off other potential clients. It is also reported that HTC sites rarely empower their clients to request for same-sex counselling (Hamilton et al., 2008, p. 398). Clients may not be confident enough to talk about intimate issues with counsellors of another sex, and this may hinder them from asking questions or discussing sexual matters which are important for their understanding of HIV/AIDS.

The right to health has been defined under the Universal Declaration of Human Rights (1948) which states that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including … medical care …" (UN, Article 25). The International Covenant on Economic, Social and Cultural Rights (1966) also recognizes the right of all people to enjoy the highest attainable standard of physical and mental health (OHCHR, 2007, Article 12 [1]). In addition, CEDAW (1979) calls on its member states to eliminate discrimination against women in health care, to ensure equality in the access of health care services and to make sure women have the right information, counselling and services of family planning (OHCHR, 2007, Article12 &14 [2b]). With regard to the rights of children, the Convention on the Rights of the Child (1989) identifies the right of the child to the enjoyment of the highest attainable standard of health and call on states to ensure that no child is deprived of his or her right to access health care (OHCHR, 2007, Article 24). In the African context, the Maputo Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2003) states that "*States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted*" (ACHPR, Article 14).

An important declaration that is a cornerstone to public health is the Alma-Ata Declaration (1978) which reaffirms that health is a basic human right and that in order to realize the attainment of the highest possible standard of health action is needed from the social and economic sectors (UN, Article 1). During the Beijing conference (1995), women's rights were also added to include the right to enjoy the highest attainable standard of physical and mental health (UN, Division for the Advancement of Women, Para 89). In addition, state parties to the Copenhagen Declaration (1995) commit to ensure an integrated and intersectoral approach in providing protection and promotion of health for all in economic and social development (UN, Commitment 6[o]).

4.3.4 The Right to be Free from Discrimination on the Basis of Sex

In all the types of gender based violence in HTC, the woman is the sole victim. This shows there is discrimination of women in HTC on the basis of their sex. As stated earlier in this chapter, CEDAW (1979) defines discrimination as *"Any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women …''* (OHCHR; 2007, Article 1). In addition, Recommendation No. 19 of CEDAW (1992) describes discrimination as that which is directed against a woman because she is a woman (General comment 6). The fact that only women are violated also shows the aspect of gender and power relations. The way a society shapes the roles and identities of men as the superior sex and how culture discriminates women by giving more rights to men affects how men treat women in HTC settings.

4.6 Summary

Human rights perspective of gender based violence in HTC settings emphasizes the obligation of the Kenyan government to ensure the protection of the rights of clients and counsellors. Four rights violations have been identified in the HTC. These include the right to dignity, liberty and security of person, the right to be free from sexual violence, the right to the highest attainable standard of health and the right to be free from discrimination on the basis of sex. Gender based violence infringes on the fundamental human rights that have been given in international covenants such as the International Covenant on Economic, Social and Cultural Rights (1966), the International Covenant on Civil and Political Rights (1966), the Convention on the Elimination of All Forms of Discrimination against Women (1979), the Declaration on the Elimination of Violence against Women (1993), the Convention against Torture and other Cruel, Inhuman or Degrading Treatment and Punishment (1984) and the Convention on the Rights of the Child (1989). In addition, regional treaties including Protocol to the African Charter on Human and People's rights of Women in Africa (2003) and the African Charter on the Rights and Welfare of Children (1990) also give provisions to protect women and girls from violence. Kenya has signed and ratified some of the above stated covenants and treaties that provide protection to women from gender based violence. Therefore, the Kenya government is required by the international law to guarantee these rights to its citizens. However, with the exception of the Convention on the Rights of Children, Kenya has failed to domesticate the provisions of these conventions. Moreover, Kenya has not yet ratified the Protocol of the African

Charter on Human and People's Rights on the Rights of Women in Africa. Till today, the major achievement has been the enactment of the Sexual Offences Act (2006) that gives sentences to perpetrators of gender based violence. However as was shown in chapter 3, women still face inequity in the Kenyan courts that often protect the perpetrator instead of the victim. To sum up, women's human rights need to be addressed within the HTC in order to ensure the protection of clients and counsellors from gender based violence.

5. Discussion and Recommendations

As outlined previously, the aim of this thesis is to identify which HIV testing and counselling settings provide chances for gender based violence, to find out how gender and power relations influence gender based violence in the HTC and to highlight violations of human rights in the HIV testing and counselling settings.

All HTC settings have their pros and cons. However, when it comes to gender based violence, mobile, home-based as well as health care settings offer a greater potential. In the mobile settings, perpetrators may take opportunity of violating the rights of clients or counsellors as it will be hard to trace them since they move from one place to another. The home-based setting poses a danger to the safety of women especially if they are alone at home at the time of HTC. As opposed to other HTC settings, in health care facilities, medical practitioners have the authority to medically examine their patients; therefore there is a great chance that perpetrators may undertake unnecessary body examinations with the aim of sexually abusing their clients. It should be the responsibility of the Ministry of Health to create regulations for all HTC settings. Though the Kenya National AIDS and STI Control Programme has laid out national guidelines for all HTC settings, there is need to specify codes of conduct for HTC service providers depending on their working environment.

Findings from the analysis show a number of human rights that are violated through gender based violence in HTC settings. These include the right to dignity, liberty and security of person, the right to be free from sexual violence, the right to the highest attainable standard of health and the right to be free from discrimination on the basis of sex. Failure to ensure that these fundamental human rights are not infringed upon shows that the Kenyan government is not abiding to the international human rights instruments that it ratified. Furthermore, it shows the lack of responsibility and accountability on the side of service providers in protecting their clients and counsellors. Kenya is on the verge of trying to reach its HIV coverage testing goal of 80% by the end of 2010. KAIS (2007) reveals that 83.6% of HIV-infected Kenyans do not know of their infection (p. 10). This shows that there is a high HTC coverage gap and that efforts to bridge this gap may end up putting issues of quality assurance at a hold. The rapid scale up of HIV testing and counselling in Kenya should be backed up by regular monitoring and evaluation of the HTC services.

There are certain limitations to this research. First, is that the research is solely based on literature reviews. This is because the thesis has not been written in Kenya and therefore it was not possible to make interviews in different HTC settings. Secondly, the issue of gender based violence in HTC rooms is very recent in Kenya and has not been extensively researched. There is only one qualitative study on this topic and therefore there is no similar study to compare it with. Furthermore, the qualitative study undertaken is not representative of the whole of Kenya as it only took place in three out of eight provinces in Kenya. Though these provinces are highly populated in comparison to others, further research on the issue of gender violence in HTC settings is necessary.

Findings of this thesis will help to view the issue of gender based violence in HTC settings from a human rights perspective. The human rights of clients and counsellors should be protected and promoted in all HTC settings. The fact that women are the only victims shows that the rights of women have not been given a priority in the HTC settings. Since vulnerability of women to gender based violence is often caused by social and cultural inequalities, HTC officials should see to it that women are not subjected to violence during counselling. In contrast to other international human rights treaties on violence against women, Kenya has domesticated the convention on the rights of children, yet these very rights are being violated in the HTC rooms. The Kenya government should take actions to protect children in all health facilities from child sexual abuse and adopt measures to prosecute the perpetrators. The fact that only women have been mentioned as the sole victims does not exclude the possibility that men, especially young boys could also be victimized inside the HTC rooms. Therefore sensitization of both women and men in HTC settings on gender based violence is essential.

Recommendations

The Kenyan government has adopted new policies that allow for the suspension of counsellors during investigations of allegations of gender based violence and in confirmed cases, the perpetrators are deregistered. Interventions such as public awareness, education and information regarding the correct process of HTC as well as circulation of leaflets and media advertising have been used to empower members of communities on what to expect in the HTC sites. Furthermore, structural measures such as the use of windows with semi-transparent glass and unlocked doors have been undertaken in some HTC. In addition, quality assurance measures e.g. the use of mystery clients have been adopted (Hamilton et al., 2008, p. 395).

Other measures that can be used to end violence against women in HTC settings as well as make human rights realizable for clients and counsellors include:

a) Educational / informative measures

Children should have greater access to information about human rights and gender violence. This can be achieved through introduction of human rights topics and sexual education in the school curricula. Textbooks that inform and teach pupils and students of their basic human rights could help them be aware of their rights so that they can escape from situations that violate their rights. Information on clients' human rights should be displayed in the HTC sites so as to educate all clients. This would help clients to know when a counsellor is about to violate their rights e.g. in the case of intimate physically examinations. Posters with pictures showing the process of HTC should also be introduced since not all people in Kenya are literate. Initiatives should be undertaken to sensitize counsellors about their rights, those of the clients and also the need to respect these rights. A human rights perspective should also be introduced and promoted in the counsellor training programmes. This would for example help future counsellors to see the right to health not only in line with the WHO definition but also in a broader social context in which the right to health is interdependent on and interrelated to other human rights such as the right to be free from sexual violence

b) Protective and quality assurance measures

Use of both a male and female counsellor during home-based HTC serves as protection for the female client in case her husband is not available at the time of HTC. Furthermore, couple counselling should be encouraged so as to provide protection to the female client through her husband/partner. With reference to this, it is important that these counsellors are well trained on how to counsel couples so as to be able to correctly address the issue of violence among the couples. The presence of a third party (the counsellor) also offers the female client protection from domestic violence that could occur if the woman is found to be HIV positive. Another protective measure is to empower clients to request for same-sex counselling. This would require HTC settings to ensure that the number of female and male counsellors is almost equal. In addition, establishment of complaint mechanisms in all HTC settings would help clients to know where they can report cases or attempts of violence. Complaint mechanisms can also help in finding out the perpetrators of gender based violence in HTC. So as to make evaluation of HTC services easier, evaluation forms for clients should be developed. These evaluation forms should serve to identify

whether the HIV testing and counselling process happened as it was described to the clients and should thus be given to clients after the post-test counselling session.

c) Governmental measures

The Kenyan government should take responsibility of the safety of those seeking HTC services and also provide means of redress for those whose rights are violated. Human rights laws that address VAW and have been ratified by the government should be implemented instead of being shelved. Not only should they be implemented but also a top down commitment by parliament is necessary in order to assure that these rights are actually being practiced in Kenya. Though the new Constitution (2010) now offers equal rights for women in Kenya, these rights are yet to be implemented and therefore all institutional bodies that govern the HTC services should be held accountable for protecting the rights of clients and counsellors. In addition, the National AIDS and STI Control Programme (NASCOP) needs to introduce codes of conduct in the national guidelines for HTC in Kenya. These codes should also be specified for each HTC setting.

6. Conclusion

In the pursuit of scaling up HTC services in Kenya, the issue of gender based violence has been overlooked. Potential for gender based violence in HTC is shown to be high in stand-alone, mobile, home-based and health care settings. Assurance of quality of service may be difficult in stand-alone sites since they are run by private organizations, high costs for supervision of services hinder control of mobile HTC, women who are home-alone can face violence in home-based settings while integration of other services as well as high work load give no room to control HTC in health care settings. The occurrence of gender based violence in HTC shows lack of ethical standards in the HTC process in Kenya. Being a patriarchal country, cultural practices have brought up Kenyan men to act with superiority over women, while women have learnt to be submissive. Furthermore, gender inequalities place women in vulnerable positions that make it easy for men to violate their rights. It is therefore gender and power relations between a man and woman in the HTC that causes gender based violence. Women's rights were not an obvious thing in the past in many countries. Violence against women was and still is in some countries like Kenya a private issue, for example domestic violence. It was only through a global campaign by women NGOs that the rights of women are realized as inalienable, integral and indivisible part of the universal human rights. There is dire need to implement measures to protect the human rights of women in HTC settings so as to enhance their uptake of HTC services. Education of women and girls on their human rights will empower them to defend themselves. Furthermore, HTC should empower women to ask for same-sex counselling. Other measures that will protect the rights of women include use if a male and female counsellor during home-based HTC and also the government's commitment to domesticate human rights instruments that address gender based violence. The new Constitution has shown a step towards realizing equality for women in Kenya. Implementation of this law should also be extended within the HTC settings.

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Eidesstattliche Erklärung

Ich versichere, dass ich die vorliegende Bachelorarbeit ohne fremde Hilfe selbständig verfasst und nur die angegebenen Hilfsmittel benutzt habe. Wörtlich oder dem Sinn nach aus anderen Werken entnommene Stellen sind unter Angabe der Quelle kenntlich gemacht.

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Hamburg, den 31. August 2010.