

Scaling-up Programs to Reduce Human Rights- Related Barriers to HIV, TB and Malaria Services

Baseline Assessment - Kenya

07 July 2021

Table of Contents

Disclaimer	7
Acknowledgements	7
List of Acronyms	7

1. Executive Summary **9**

Introduction

Methods and Limitations

Summary of Baseline Assessment Findings

- (a) Key and Vulnerable Populations
- (b) Human Rights-related Barriers to HIV Services
- (c) Comprehensive Programs to Reduce Human Rights-related Barriers to HIV Services
- (d) Human Rights-related Barriers to TB Services
- (e) Existing Programs to Address Human Rights-Related Barriers to TB Services
- (f) Comprehensive Programs to Reduce Human Rights-related Barriers to TB Services
- (g) Human Rights-related Barriers to Malaria Services
- (h) Existing Programs to Address Human Rights-related Barriers to Malaria Services
- (i) Comprehensive Programs to Reduce Human Rights-related Barriers to Malaria Services

Next Steps

2. Introduction **22**

Purpose, Objective, and Expected Outcomes of the Baseline Assessment

3. Methodology **23**

Conceptual Framework and Program Areas

Assessment Process

- (a) Desk Review
- (b) Preparation for In-country Research
- (c) In-country Research
- (d) In-country Interviews
- (e) Program Costing
- (f) Data Analysis

- (g) Validation and Next Steps

4. Baseline Findings – Legal and Policy Environment **28**

International Human Rights Commitments
Legal System and General Laws and Policies
Reference to Key Populations in Specific Laws
Access to Justice

5. Baseline Findings – Health System **34**

Universal Health Coverage

6. Baseline Findings – HIV **36**

HIV Epidemiology

- (a) General
- (b) Key Populations

Global Commitments

Protective Laws and Policies Relevant to Access HIV Services

- (a) National Strategy
- (b) Laws

Cultural and Social Environment Relevant to Access HIV Services

Human Rights-related Barriers to HIV Services

- (a) Punitive Laws, Policies and Practices
- (b) People Living with HIV
- (c) HIV in the Workplace
- (d) Stigma and Discrimination
- (e) Gender Inequality and Gender-based Violence
- (f) Underlying Poverty and Economic Inequality
- (g) Health System Factors Affecting the Availability and Accessibility of HIV Services

Existing Programs to Address Human Rights-Related Barriers to HIV Services

- (a) Introduction
- (b) Stigma and Discrimination Reduction
- (c) Training for Health Care Workers on Human Rights and Medical Ethics Related to HIV
- (d) Sensitization of Law-makers and Law Enforcement Agents
- (e) Legal Literacy (“Know Your Rights”)

- (f) HIV-related Legal Services
- (g) Monitoring and Reforming Laws, Regulations and Policies Relating to HIV
- (h) Reducing Discrimination Against Women in the Context of HIV

7. Baseline Findings – TB

75

TB epidemiology

- (a) General
- (b) Key and Vulnerable Populations

Protective Laws and Policies Relevant to Access TB services

- (a) National Strategy
- (b) Policies

Human Rights-related Barriers to TB Services

- (a) Punitive Laws, Policies, and Practices
- (b) Stigma and Discrimination
- (c) Gender Norms
- (d) Underlying Poverty and Economic Inequality
- (e) Availability and Accessibility of TB Services
- (f) Lack of Information
- (g) Barriers for Key Populations

Existing Programs to Address Human Rights-related Barriers to TB Services

- (a) Introduction
- (b) Reducing Stigma and Discrimination
- (c) Reducing Gender-based Barriers to TB Services
- (d) TB-related Legal Services
- (e) Monitoring and Reforming Policies, Regulations and Laws that Impede TB Services
- (f) Legal Literacy (“Know Your TB-related Rights”)
- (g) Training of Health Care Providers on Human Rights and Ethics Related to TB
- (h) Ensuring Confidentiality and Privacy
- (i) Mobilizing and Empowering Patient and Community Groups
- (j) Programs in Prisons and Other Closed Settings

8. Baseline Findings – Malaria

96

Malaria Epidemiology

- (a) General
- (b) Key and Vulnerable Populations

Protective Laws Relevant to Access Malaria Services

- (a) National Strategy
- (b) Laws

Human rights-related barriers to malaria services

- (a) Underlying Poverty and Economic Inequality
- (b) Gender Inequalities
- (c) Discriminatory Barriers to Accessing Primary Healthcare and Malaria-specific Services
- (d) Availability and Accessibility of Malaria Services
- (e) Barriers for Vulnerable Populations

Existing Programs to Address Human Rights-related Barriers to Malaria Services

- (a) Introduction
- (b) Human Rights and Gender Assessments
- (c) Meaningful Participation of Affected Populations
- (d) Strengthening of Community Systems for Participation in Malaria Programs
- (e) Addressing Gender-related Vulnerabilities and Barriers
- (f) Improving Access to Services for Refugees and Others Affected by Emergencies
- (g) Malaria in People Living with HIV
- (h) Improved Services in Prison and Pre-Trial Detention

9. Investments in HIV, TB and Malaria Programs (2017) 111

10. Comprehensive Programs to Remove Human Rights-Related Barriers to HIV, TB and Malaria Services 115

Introduction

- (a) Overarching Contextual Issues
- (b) Overarching Principles

Optimal Program Mix for a Comprehensive Response to Human Rights-related Barriers to HIV, TB and Malaria Services

- (a) HIV and TB Programs
- (b) Malaria Programs

Support to Implementation Capacity

Monitoring Impact of Comprehensive Programs to Remove Human Rights-Related Barriers Across Program Areas

- (a) Qualitative Assessment
- (b) Quantitative Assessment
- (c) Policy Assessment

11. Conclusion**158**

12. Annexes**159**

Annex 1: International Human Rights Commitments Relating to HIV, TB and Malaria

Annex 2: Protective Laws for Specific Relevant Populations in the Context of HIV

Annex 3: Laws that Create Barriers for Men Who Have Sex with Men in the Context of HIV

Annex 4: Laws that Create Barriers for People Who Use Drugs in the Context of HIV

Annex 5: Laws that Create Barriers for People Who Engage in Sex Work in the Context of HIV

Annex 6: Laws that Create Barriers for Women/Girls in the Context of HIV

Annex 7: Protective laws relevant to HIV

Annex 8: Laws Criminalizing HIV Transmission and Non-disclosure that Create Barriers to Accessing Services

Annex 9: Protective National Laws Relevant for TB for Key Populations

Annex 10: Laws Relevant to TB that Might Constitute Barriers for Key Populations

Annex 11: Laws Relevant to Malaria

Annex 12: List of organizations participating in key informant interviews, focus group discussions and provision of programmatic information

Annex 13: Documents Reviewed for the Desk Review

Annex 14: Documents Received and Reviewed After In-Country Data Collection

Annex 15: Cited References

Disclaimer

Toward the operationalization of Strategic Objective 3(a) of the Global Fund Strategy, *Investing to End Epidemics, 2017-2022*, this paper was commissioned by the Global Fund to Fight AIDS, Tuberculosis and Malaria. Supplemental funding was provided by Stop TB to cover the TB component of this work. The paper presents research findings that are relevant to reducing human rights-related barriers to HIV, TB and malaria services in Kenya and to implementing a comprehensive programmatic response to such barriers. The views expressed in the paper do not necessarily reflect the views of the Global Fund or Stop TB.

Acknowledgements

With regard to the research and writing of this report, the Global Fund acknowledges the work of the Program on Global Health and Human Rights at the University of Southern California (USC) in partnership with John Snow Inc. (JSI) and the Kenya Legal & Ethical Issues Network on HIV and AIDS (KELIN), as well as country and technical partners and many others who inputted into the report.

List of Acronyms

- AIDS - Acquired Immunodeficiency Syndrome
- ART - Antiretroviral Therapy
- ARV- Antiretroviral
- BLAST - Building Lives Around Sound Transformation
- BHESP - Bar Hostess Empowerment and Support Program
- CSO - Civil Society Organization
- DOTS - Directly Observed Treatment Short Course
- EGPAF - Elizabeth Glaser Pediatric AIDS Foundation
- HAPA Kenya- HIV and AIDS People Alliance of Kenya
- IPTp - Intermittent Preventive Treatment in Pregnancy
- IRB - Institutional Review Board
- IRS - Indoor Residual Spraying
- JSI - John Snow, Inc.
- KASF - Kenya AIDS Strategic Framework
- KAPTLD - Kenyan Association for the Prevention of TB and Lung Diseases
- KELIN - Kenya Legal & Ethical Issues Network on HIV and AIDS

- KEMRI - Kenya Medical Research Institute
- KEMSA - Kenya Medical Supplies Authority
- KeNAAM - Kenya NGO Alliance Against Malaria
- KESWA- Kenya Sex Workers Alliance
- KMS - National Strategic Plan for Kenya Malaria Strategy
- KPI - Key Performance Indicator
- MDR-TB - Multi-drug Resistant TB
- MDR/RR-TB - Multi-drug Resistant/Rifampicin Resistant TB
- Ministry of Health - MOH
- NACC - National AIDS Control Council
- NASCOP - National HIV/AIDS and STD Control Program
- NEPHAK - National Empowerment Network of People living with HIV & AIDS
- NGO - Non-Governmental Organization
- NHIF - National Hospital Insurance Fund
- NMCP - National Malaria Control Program
- NTLD - National Tuberculosis, Leprosy and Lung Disease Program
- PEPFAR - U.S. President's Emergency Plan for AIDS Relief
- PLHIV - People Living with HIV
- SRH - Sexual and Reproductive Health
- TB - Tuberculosis
- UHC - Universal Health Coverage
- UNAIDS - Joint United Nations Program on HIV/AIDS
- UNDP - United Nations Development Program
- USC - University of Southern California
- USD - United States Dollar
- WHO - World Health Organisation
- WOFAK - Women Fighting AIDS in Kenya

1. Executive Summary

Introduction

Since the adoption of its strategy, *Investing to End Epidemics, 2017-2022*, the Global Fund has joined country stakeholders, technical partners and other donors in a major effort to expand investment in programs to remove human-rights related barriers in national responses to HIV, TB and malaria. It has done so because it recognizes that these programs are an essential means by which to increase the effectiveness of Global Fund grants as they help to ensure that health services reach those most affected by the three diseases. This report comprises the baseline assessment conducted in Kenya as part of operationalizing Strategic Objective 3, which commits the Global Fund to Fight AIDS, TB and Malaria to: “*introduce and scale-up programs that remove human rights barriers to accessing HIV, TB and malaria services*” (The Global Fund, 2016).

Though the Global Fund will support all countries to scale-up programs to remove human rights-related barriers to health services, it has provided under the Breaking Down Barriers initiative intensive support to 20 countries to enable them to put in place comprehensive programs aimed at reducing such barriers (The Global Fund, 2016). “Comprehensive” programs are programs that: (a) comprise a set of activities that are internationally recognized as effective in reducing human rights-related barriers to health; (b) are accessible or serve the majority of the estimated numbers of key and vulnerable populations affected by such barriers; and (c) are adequately resourced to move from non-existence or one-off/small-scale activities to a level of implementation likely to significantly reduce human rights-related barriers to services (a sustained, mutually-reinforcing, broadly protective package at scale)¹ Based on criteria involving needs, opportunities, capacities and partnerships in country, Kenya and 19 other countries were selected for intensive support.² This baseline assessment is the first component of the package of support Kenya will receive and is intended to provide the country with the data and analysis necessary to identify and implement comprehensive programs to remove barriers to HIV, TB and malaria services.

Toward this end, this assessment: (a) establishes a baseline concerning the present situation in Kenya with regard to human rights-related barriers to HIV, TB and malaria services and existing programs to remove them, (b) describes comprehensive programs aimed at reducing these barriers and their costs, and (c) suggests opportunities regarding possible next steps in putting

¹ This definition of “comprehensiveness” for the purpose of GF Key Performance Indicator 9 was developed with the Global Fund Human Rights Monitoring and Evaluation Technical Working Group.

² The 20 countries are Benin, Botswana, Cameroon, Democratic Republic of Congo (province-level), Cote d'Ivoire, Ghana, Honduras, Indonesia (selected cities), Jamaica, Kenya, Kyrgyzstan, Nepal, Mozambique, Philippines, Senegal, Sierra Leone, South Africa, Tunisia, Uganda and Ukraine. https://www.theglobalfund.org/media/1213/humanrights_2016-removingbarrierspart2_qa_en.pdf

comprehensive programs in place. As a working draft, this report will be shared extensively with a broad range of partners for input, including at a multi-stakeholder meeting in country where country stakeholders, the Global Fund and other donors, and technical partners can use its findings, as well as other relevant information, for the basis of the development of a mutually-agreed upon and cost-shared plan by which to fund and implement a comprehensive response to human rights-related barriers to HIV, TB and malaria services in Kenya.

The key program areas involving interventions and activities to remove human rights-related barriers to services are those recognized by governments, technical partners, beneficiaries and other experts as effective in doing so. For HIV and TB, these program areas comprise: (a) stigma and discrimination reduction; (b) training for health care providers on human rights and medical ethics; (c) sensitization of law-makers and law enforcement agents; (d) reducing discrimination against women in the context of HIV and TB; (e) legal literacy (“know your rights”); (f) legal services; and (g) monitoring and reforming laws, regulations and policies relating to HIV and TB (The Global Fund, 2017b). In addition, for TB, there is the need to: ensure confidentiality and privacy related to TB diagnosis, mobilize and empower TB patient and community groups, and make efforts to remove barriers to TB services in prisons and closed settings (The Global Fund, 2017d). For malaria, these program areas comprise: (a) human rights and gender assessments; (b) meaningful participation of affected populations; (c) strengthening of community systems for participation in malaria programs; (d) addressing gender-related vulnerabilities and barriers; (e) improving access to services for refugees and others affected by emergencies; (f) malaria in people living with HIV; and (g) improved services in prison and pre-trial detention.

Methods and Limitations

This baseline assessment examined human rights-related barriers in Kenya that inhibit access, uptake, and retention of HIV, TB and malaria services. Data collection included a desk review that also involved four key stakeholder interviews with local non-governmental organizations (NGOs)/civil society organizations (CSOs) and implementing agencies, followed by in-country work. In-country work consisted of key informant interviews and focus group discussions. Eighty-one key informant interviews were carried out with national and county level government officials; staff from NGOs/CSOs supporting services among key populations and/or implementing programs to remove human rights-related barriers to HIV, TB, and malaria services; and officials from multilateral technical agencies. Key informant interviews by disease were carried out as follows: ten represented all three diseases, twenty-four represented HIV and TB, thirty represented HIV only, five represented TB only, and nine represented malaria only. Three interviews covered general issues, such as use of courts, training of police, and health systems. Eighteen focus group discussions, with a total of 110 focus group discussion participants, were carried out with key and vulnerable populations including people living with HIV, sex workers, men who have sex with men, transgender populations, people who use drugs, people with physical disabilities, young women, and mothers of young children. Focus

group discussions by disease were carried out as follows: two represented all three diseases, ten represented HIV and TB, three represented HIV only, and three represented TB only. The interviews and focus group discussions were carried out in Nairobi, Mombasa, Kisumu, and Kitui counties. While the focus of interviews was in these four counties, to the extent possible, information was also captured about surrounding areas (e.g. data collection in Mombasa also asked about neighboring counties such as Kwale and Kilifi) and the country as a whole.

Limitations to the assessment included the following. Due to Institutional Review Board restrictions, it was not possible to speak to certain key stakeholders, including but not limited to adolescents under the age of 18, prisoners, male or trans sex workers and people in extreme poverty. Moreover, relatively few inputs were received from people outside the four counties where primary data collection took place. The report provides data from the desk review as well as the focus group discussions and key informant interviews. This data is important in understanding the views of a sample of representatives of key affected populations and relevant stakeholders, but in a number of cases, data collected might have been the participants' opinions and did not undergo validation through data triangulation or other analytical methods. Further, the sample of those reached is relatively small, and does not include broad representation across key and vulnerable populations and across diseases. Thus, a number of views and concerns may not have been adequately captured. Finally, the research was carried out with a focus on existing programs to remove human rights-related barriers to services as they are existing in 2017. Given that the report intended to set a baseline prior to the scaled-up GF investment, including human rights matching funds, the report did not fully capture a significant increase in efforts in 2018.

Summary of Baseline Assessment Findings

(a) Key and Vulnerable Populations

For the purposes of the desk review and baseline assessment, key and vulnerable populations in relation to HIV, TB, and malaria in Kenya were determined based on the Global Fund criteria (The Global Fund, 2013, 2017b, 2017c, 2017d, 2019) and national strategies in Kenya for each disease (Ministry of Health, 2014a, 2019; National Malaria Control Program, 2019). These groups are presented in Table 1. This evaluation attempted to assess the barriers and programs for as many of these populations as possible as relevant to each disease.

Table 1: Key and vulnerable populations in Kenya based on Global Fund criteria³ and Government of Kenya strategies

	Global Fund		Kenya's Strategic Plan
	Key Populations	Vulnerable Populations	Key/Vulnerable Populations
HIV	<ul style="list-style-type: none"> Men who have sex with men All transgender people People who use/inject drugs People who engage in sex work Prisoners and incarcerated populations People living with HIV 	<ul style="list-style-type: none"> Women Children People living in extreme poverty 	<ul style="list-style-type: none"> Men who have sex with men People who use/inject drugs People who engage in sex work Women and young girls Children Children and pregnant women living with HIV People in prisons and other closed settings People living with HIV (including sero-discordant couples) Fishing communities, truck drivers, street children, people with disabilities, migrant populations especially those in humanitarian crisis and mobile workers Vulnerable populations described as - Populations whose social contexts increase their vulnerability to HIV risk⁴
TB	<ul style="list-style-type: none"> People living with HIV Prisoners and incarcerated populations Mobile or displaced populations People with drug sensitive, Multi-drug Resistant/Rifampicin Resistant TB (MDR/RR-TB) 	<ul style="list-style-type: none"> Women/Men Children Health care workers People living in extreme poverty 	<ul style="list-style-type: none"> People who are undernourished People living with HIV People with cancer/ undergoing immunosuppressive therapy People who have diabetes People with cancer/ undergoing immunosuppressive therapy People who misuse alcohol People who use/inject drugs Elderly over 65 years People who live in urban slums Health care workers Prisoners People living or working in congregate settings with an index case - school going children in boarding schools, informal workers in factories/ plantations with large number of employees⁵
	Underserved or High Risk Populations		Key/Vulnerable Populations
Malaria	<ul style="list-style-type: none"> People living with HIV Prisoners and incarcerated populations Mobile or displaced populations Women and pregnant women Children People living in extreme poverty Populations living in hard to reach areas 		<ul style="list-style-type: none"> Those living in malaria endemic areas (lake and coastal regions)⁶

³ As specified in the GF KP Action Plan 2014 – 2017, a group will be deemed to be a key population in the context of AIDS, TB and malaria if the 3 cumulative criteria are met – the group experiences a high epidemiological impact from one of the diseases combined with reduced access to services, and being criminalized or otherwise marginalized.

https://www.theglobalfund.org/media/1270/publication_keypopulations_actionplan_en.pdf

⁴ Ministry of Health. (2014). Kenya AIDS Strategic Framework 2014/2015 - 2018/2019.

⁵ Ministry of Health. (2019). Republic of Kenya - National Strategic Plan for Tuberculosis, Leprosy and Lung Health 2019-2023.

⁶ National Malaria Control Program. (2019). Kenya Malaria Strategy 2019–2023.

(b) Human Rights-related Barriers to HIV Services

The major human rights-related barriers to HIV services that were observed are summarized as follows:

- **Punitive laws, policies, and practices relevant to HIV:** Kenya has a strong Constitution, and some laws and policies exist that are intended to be protective of populations key and vulnerable to HIV and favorable to accessing health services. However, implementation and enforcement of the legal framework can be weak or inconsistent. Furthermore, punitive laws, policies and practices also exist and act as major barriers to HIV services, particularly for some key populations. In many places, police engage in illegal police practices against key populations. These practices include harassment, extortion, arbitrary arrest, violence (including sexual violence) and the failure to protect members of these populations when in danger. Instances of mandatory HIV testing in relation to employment and coerced sterilization of women living with HIV have been reported. Lack of clarity around the legal framework for people under the age of 18, with regard to access to services, particularly when the young people are members of a key population, hamper access for some of the most vulnerable.
- **Stigma and discrimination relevant to HIV:** Stigma and discrimination remain pervasive in Kenya, both in relation to positive HIV status and to belonging to a key population, with a negative impact on access to and uptake of HIV-related services. This includes stigma and discrimination across a range of settings including schools, workplaces, health facilities and communities. It is particularly pronounced in more rural areas. Members of key and vulnerable populations face layered stigma and discrimination, the manifestations of which vary by population but which can constitute major barriers to services.
- **Gender inequality and gender-based violence:** The HIV epidemic in Kenya has had a disproportionate impact on women and girls, including trans women, and they face particular challenges accessing services. Gender-based violence is pervasive, particularly if a woman is diagnosed with HIV, and also for adolescent girls who face their own particular age and culture-related challenges to accessing services.
- **Underlying poverty and economic inequality:** Underlying poverty was an almost universally-cited barrier to accessing HIV services. Although treatment is free, the ancillary costs are prohibitive. These costs include transport and testing, as well as costs associated with medication if this has to be procured from a private pharmacy due to health facility stockouts. Women and young people, as well as those in extreme poverty, who may have less access to financial resources, are disproportionately affected.
- **Availability and accessibility of HIV services:** Uneven distribution of health facilities and healthcare personnel, lack of referral mechanisms, and poor infrastructure and information management systems all impede the availability and accessibility of HIV (and other health) services. These barriers are particularly strong in rural areas. Frequent stockouts of drugs and other commodities, as well as the low quality of antiretrovirals, were highlighted as challenges. Access to HIV-related information continues to be a problem, particularly for young people and those of low socioeconomic status.
- **Existing programs to address human rights-related barriers to HIV services**

There are many programs that address human rights barriers to HIV services, as well as many gaps and areas for improvement. Examples of recent or current interventions to address human rights-related barriers to HIV services are summarized below.

Stigma and discrimination reduction activities include a wide range of peer support/education programs, community education through community leaders, dialogues and workplaces, and research to better understand how stigma manifests.

Community health volunteers and peer educators have been widely used and have had a positive impact on support to the HIV response. There has been widespread training for healthcare workers on human rights and medical ethics related to HIV, and the diversity of content, depth and duration is striking.

Similarly, many organizations have carried out in-services training for lawmakers, judges and law enforcement agents on HIV and human rights. Judges, magistrates and prosecutors have also been trained recently, with “trickle-down” training occurring.

With little funding, small-scale legal literacy efforts have been carried out across the country and with different populations including people living with HIV, sex workers, men who have sex with men, people who use drugs, young people and prisoners.

In an effort to promote access to justice, there has been extensive training of paralegals, as well as some training of *pro bono* lawyers, to support HIV-related cases. The HIV/AIDS Tribunal is also an important avenue for accessing HIV-related justice.

Many NGOs are involved in monitoring and seeking to reform laws, regulations and policies relating to HIV through, for example, building the capacity of key population members or community-based organizations with a view to expanding the network of individuals and organizations who can participate in this work, or seeking to directly influence laws, regulations and policies through a range of different strategies.

There are many small-scale efforts to reduce discrimination against women in the context of HIV, but the largest-scale program which has produced remarkable results is PEPFAR’s DREAMS program that has been implemented in seven counties⁷. Other important work in this area includes alternative dispute resolution that is currently supported by some local NGOs.

However, there are significant gaps in programs to reduce human rights-related barriers to HIV services including:

- Lack of standardization of peer education training relating to HIV, TB and human rights and consistent support to peer educators
- Lack of standardization of training for healthcare workers; with insufficient continuous engagement and the need to be scaled up
- Lack of clarity of the legal framework within which community health volunteers operate

⁷ Homabay, Siaya, Kisumu, Migori, Nairobi, Kiambu, and Mombasa

- Insufficient coverage and follow-up for trainings of health care workers on human rights and medical ethics related to HIV
- Lack of standardization of training for law-maker (parliamentarians), judges and law enforcement officers
- Insufficient scale/scope of sensitization of police and police management on the rights of key populations and the need to avoid illegal police practices and support access to health services
- Lack of large-scale legal literacy efforts specifically targeting the issues and needs of different stakeholders
- Lack of standardization, scale-up of and support for paralegal training
- Lack of decentralized access to the HIV/AIDS Tribunal
- Need for stronger county-level structures to facilitate civil society engagement in policy-making and monitoring of implementation
- Lack of strong, coherent human rights interventions to address HIV among adolescent girls and young women in many high burden counties
- Lack of psychosocial support for survivors of gender-based violence
- Limited monitoring and evaluation of human rights-related program impacts on addressing barriers to services; and
- Uncertainty about program sustainability, impacting capacity and the ability of organizations concerned with the human rights dimensions of HIV to operate to the best of their ability.

(c) Comprehensive Programs to Reduce Human Rights-related Barriers to HIV Services

This section summarizes recommendations for program areas that would help Kenya address the gaps outlined above, and achieve a more comprehensive response to human rights-related barriers to HIV services. These recommendations should be viewed as opportunities for stakeholders engaged in addressing barriers to access to HIV services in Kenya to scale-up and/or complement existing programming, and are set forth in more detail in the body of the report.

The list below is not exhaustive but provides some examples of a more comprehensive package of interventions that, building on current efforts, could help remove human rights-related barriers to HIV services. Additional interventions and further details on those listed here are found in the appropriate section of the report.

- Expansion of peer educator programs based on standardized training that includes explicit attention to and competence in HIV- and TB-related human rights issues
- Roll-out of surveys to measure stigma and discrimination in health care settings, as well as in communities, workplaces, schools, prisons, humanitarian settings and the military.
- Media campaigns, combining a national campaign and local campaigns across different media, to reduce HIV-, TB- and key population-related stigma and discrimination. This should include raising awareness of human rights related to HIV, TB, health and key populations; as well as other anti-discrimination campaigns carried out in workplaces, schools, communities, prisons, in humanitarian settings and among the military
- Regular meetings of county-level multi-stakeholder technical working groups sensitized on human rights in the HIV and TB responses

- Standardization and coordination of pre-service and in-service training for healthcare workers on human rights and medical ethics
- Standardization and coordination of pre-service and in-service training for police, prison officers, judges, magistrates, prosecutors and legal researchers to include training on human rights in relation to HIV and TB
- HIV and health-related capacity-building of Court Users Committees
- Large-scale legal literacy trainings covering HIV- and TB-related rights that includes and leads to support for community-mobilization around advocacy for law reform and against punitive laws affecting particular key populations
- Expansion of paralegal programs based on standardized training that includes explicit attention to HIV- and TB-related human rights issues and the skills and knowledge to address these
- Decentralization of the HIV/AIDS Tribunal (accompanied by appropriate capacity building)
- Large-scale training on human rights for community health volunteers and advocacy for their continued support
- Integration of psychosocial support to and legal literacy for GBV survivors and their families into existing GBV-related programs
- Capacity building and support to gender- and rights-sensitive alternative dispute resolution mechanisms that are acceptable to local communities

As noted above, many of these interventions also contribute to removing barriers to accessing TB services.

(d) Human Rights-related Barriers to TB Services

The major human rights-related barriers to TB services can be summarized as follows:

- **Punitive laws, policies, and practices relevant to TB:** There have been recent positive developments in the policy framework relevant to TB. However, knowledge and understanding of these changes, for example, the new TB Isolation Policy, remains low among stakeholders, meaning that practices do not always align with the policy. Punitive practices within health facilities have also been reported.
- **Stigma and discrimination relevant to TB:** TB-related stigma and discrimination, including self-stigma, remain strong in Kenya, partly, but not entirely, due to the association with HIV. This was reported in workplaces, health facilities and communities. Rates of screening and self-reporting of TB diagnosis is low among healthcare workers for fear of discrimination. Key population-related stigma may impede this populations from seeking TB-related services.
- **Gender norms:** TB disproportionately affects men in Kenya, particularly working-age men who, due to prevailing gender norms, might be unwilling to access services for seemingly mild symptoms. Fear of lost wages or lost employment is another barrier for men to access TB services. Among women, it is older women who are most affected, perhaps due to lower immunity due to age. They may face challenges accessing services if they need a man's permission to access services.
- **Underlying poverty and economic inequality:** Congested housing conditions in many areas, which are linked to underlying poverty, increase vulnerability to TB. Those who are economically

disadvantaged tend to delay seeking care which perpetuates the spread of TB. For those needing treatment, it can be difficult to schedule an appointment at a time that does not infringe on work, especially for informal or casual laborers who are paid per day and have very little job security. The level of catastrophic expenditures associated with TB, particularly MDR-TB is alarming. Furthermore, food insecurity is an important barrier to treatment adherence.

- **Availability and accessibility of TB services:** Distance to TB services constitutes a major access barrier in rural areas. Across the country, frequent drug stock-outs and healthcare worker shortages have led to a loss of trust in government health facilities among some communities. There is also widespread lack of information about TB transmission and prevention. Prison conditions, including overcrowding and lack of isolation facilities, exacerbate the spread of TB. There is a lack of protection for healthcare workers in health facilities and prisons alike.

(e) Existing Programs to Address Human Rights-Related Barriers to TB Services

There is significantly less programming specific to removing human rights-related barriers to TB services than there is for HIV services. As might be expected, there is substantial integration of TB and HIV programs, including those to address human rights related barriers to HIV and TB services, with many programs concurrently addressing both issues. Those have been included in the HIV section above.

Many organizations are implementing programs in the area of community mobilization and education on TB-related stigma and discrimination in different parts of the country, ranging from broad community advocacy initiatives to single 'champions' working for change. Some drop-in centers have incorporated TB screening services in the hope that this provides a 'friendlier' space where key populations can access screening services.

Most gender-sensitive programming around TB has focused on increasing men's access to screening and treatment services. This includes a range of workplace programs, particularly targeting male-dominated professions and the informal sector as well as training of male community health volunteers that might be deemed more acceptable to men than the more traditional female volunteers.

There have been some *ad hoc* legal aid clinics to provide direct legal assistance to individuals living with TB or HIV, as well as some training of lawyers and paralegals on TB and human rights.

A recent assessment was carried out of the TB-related legal environment, the findings of which can be used to inform monitoring and reform of policies, regulations and laws that impede TB services. Community health advocate training has been carried out, sometimes in conjunction with community-level discussions on TB and human rights, to promote community monitoring of the right to health, including in relation to TB. Recently, an app was developed to help monitor human rights violations within health facilities.

Small-scale work has been carried out to improve legal literacy in relation to TB, including country dialogues with county health officials and affected populations, awareness-raising on human rights in the context of TB in informal settlements, and human rights training for key populations that has included content on TB.

Many of the above-mentioned trainings on HIV for lawmakers, judicial officers and law enforcement agents also include information on TB. Small scale training has also been carried out for lawyers on TB and human rights to create a cadre of lawyers willing to take on *pro bono* cases in this area.

Training of healthcare workers on human rights and medical ethics relating to TB has also been part of the above-described training for healthcare workers on HIV.

There have been substantial efforts to mobilize and empower patient and community groups, particularly through the training of community health workers and community-based activities. Home visits are an integral part of this and, for key populations, outreach at hotspots has also been effective. A safety net program is in place, implemented by the government, to support people with drug-resistant TB.

There is one major ongoing program to build capacity for TB service provision in prisons. It also includes capacity-building of inmates to identify people with symptoms of TB as well as prevention and treatment services for prison staff and their families. There is one facility for dealing with MDR-TB in the Coast Region.

(f) Comprehensive Programs to Reduce Human Rights-related Barriers to TB Services

This section summarizes recommendations for program areas that would help Kenya address the gaps outlined above, and achieve a more comprehensive response to human rights-related barriers to TB services. These recommendations should be viewed as opportunities for all stakeholders engaged in or interested in addressing barriers to access to TB services in Kenya to scale-up and/or complement existing programming, and are set forth in more detail in the body of the report.

Any interventions that should be integrated into the HIV interventions mentioned above are not repeated here. Building on current efforts, a more comprehensive package of interventions to remove human rights-related barriers to TB services could include:

- Gender-sensitive TB programs that take into account the distinct vulnerabilities and needs of women, men and trans people with or at risk of TB, including the collection of gender- rather than sex-disaggregated data
- TB workplace programs (e.g. on information, stigma reduction, early care-seeking behavior) targeting men in the informal sector as well as in quarries (mines), fishing industry, privately-owned public transportation system (matatus, boda bodas), truck drivers, and factory workers
- Standardization and roll-out of community health volunteer training, including for male community health volunteers (and appropriate ongoing support for volunteers)
- Expanded integration of TB services into drop-in centers
- Expansion of HIV and TB services work in prisons

- Advocacy for prison infrastructure improvements, including the provision of adequate facilities for the isolation of TB patients, as well as timely access to diagnosis and treatment within prisons, and
- Networking of health information systems between prisons and Ministry of Health facilities to avoid loss to follow-up.

(g) Human Rights-related Barriers to Malaria Services

The major human rights-related barriers to malaria services can be summarized as follows:

- **Underlying poverty and economic inequality:** Even though malaria diagnosis and treatment are free, the cost of transportation to a health facility is a significant barrier in accessing services, and malaria can exacerbate poverty due to loss of work and productivity.
- **Gender inequalities:** Sometimes women can face challenges accessing health services if they need their husband's permission to do so, either through his absence or lack of willingness to prioritize the woman's care-seeking. Men's care-seeking behavior for malaria is generally worse than that of women. Bednets are often only distributed to women at health facilities, ostensibly for use by pregnant women and young children, but, within the household, the bednet might be given to the man instead, leaving the woman exposed if they are not sharing a sleeping space.
- **Barriers to SBCC:** While malaria itself is not stigmatized, there is stigma around certain types of bednets in some areas leading to under-utilization. Myths around malaria medication also lower uptake, particularly sulfadoxine-pyrimethamine for intermittent preventive treatment in pregnancy.
- **Availability and accessibility of malaria services:** Many of the barriers that affect access to malaria services are the same as those affecting access to primary health care services in general. Significant barriers include distance to the health facility, cost of transportation, and drug and commodity stockouts, all of which are worse in rural areas. For services that are within health facilities, certain populations who may face barriers accessing general health services such as illegal migrants, members of HIV-related key populations and others, may also struggle to access malaria services. Although the evidence is mixed, some people have suggested that people with disabilities, due to the stigma that surrounds these conditions, are often left out of bednet distribution. The permissibility of community health volunteers administering rapid diagnostic tests remains unclear, creating challenges for the roll-out of this technology.
- **Barriers for vulnerable populations:** People in prisons and other closed settings face significant challenges accessing malaria prevention and treatment services. There are no bednets in male prisons, indoor residual spraying is rarely carried out, and rapid diagnostic

tests and treatment are often unavailable. The Ministry of the Interior is responsible for prisons and operates centrally, while the Ministry of Health, which is devolved to county-level, is responsible for health. Among other things, this appears to result in little attention from either Ministry for malaria (and other health) services in prisons. Other vulnerable populations include mobile populations such as refugees and migrant workers who also face challenges accessing malaria services.

(h) Existing Programs to Address Human Rights-related Barriers to Malaria Services

Relatively few malaria programs with a human rights focus have been identified to date. This section summarizes some of the existing programming to address human rights barriers to malaria services, as well as many gaps and areas for improvement. Examples of recent or current interventions to address human rights-related barriers to malaria services are summarized below.

A few relevant assessments have recently been carried out including a “malaria and gender” review and a “community, rights and gender” assessment, both of which were used to inform the new Kenya Malaria Strategy 2019-2023. The Kenya Malaria Indicator Survey that was implemented in 2015 disaggregated some data by sex allowing for some inferences about the gender dimensions of malaria in Kenya.

The Strategy for Community Health 2014-2019 provides a framework for community engagement in health. Civil society organizations have been active in recent strategic planning processes, which contributed to the adoption of human rights and gender as a guiding principle in the strategic plan.

Community systems are being used in various different ways with regard to malaria interventions. One critical intervention is the widespread use of community health volunteers to deliver malaria-related services including community case management of malaria and the provision of information about malaria. There have also been some communication efforts to raise awareness about malaria using fora as diverse as community barazas and national media.

Many malaria prevention strategies focus on malaria prevention among pregnant women, particularly encouraging women to attend antenatal care early so as to receive all three doses of sulfadoxine-pyrimethamine for intermittent preventive treatment in pregnancy at the appropriate gestational ages. Women and children under five are often targeted in bednet distribution programs, and specifically for routine distribution in ANC clinics.

Some work has to been done to distribute bednets and insecticides in refugee camps. Some IRS has been sporadically implemented in refugee camps.

The Government of Kenya, recognizing that people living with HIV may be more susceptible to malaria due to lowered immunity, provides access to long-lasting *insecticide*-treated nets for free as part of the HIV Basic Care Package⁸, although it does not isolate a specific human rights-based approach.

The Kenya Malaria Strategy 2019-2023 indicates that prisons are included in IRS campaigns and participate in performance monitoring, diagnosis, and treatment efforts. However, the extent to which these programs have been operationalized or successful is unclear. No additional information was found with regard to malaria services in prisons and pretrial detention.

⁸ http://guidelines.health.go.ke:8000/media/Quick_Reference_Guide_for_Basic_Care_Package.pdf

(i) Comprehensive Programs to Reduce Human Rights-related Barriers to Malaria Services

This section summarizes recommendations for program areas that would help Kenya address the gaps outlined above, and achieve a more comprehensive response to human rights-related barriers to malaria services. These recommendations should be viewed as opportunities for all stakeholders engaged in or interested in addressing barriers to access to malaria services in Kenya to scale-up and/or complement existing programming, and are set forth in more detail in the body of the report. Building on current efforts, a more comprehensive package of interventions to remove human rights-related barriers to malaria services could include:

- Strengthening health management information systems and Kenya Malaria Indicator Survey to improve availability of disaggregated data on malaria
- Expanded capacity-building for civil society organizations to participate in policy design and monitoring of implementation
- Expanded sensitization of duty-bearers on the importance of community engagement
- Advocacy to ensure a supportive policy environment for community health volunteers to administer rapid diagnostic tests, to treat uncomplicated malaria and to receive standardized payment
- Standardized and rolled out training for community health volunteers on all aspects of community case management, gender and human rights (perhaps linked to efforts on this under the TB program), including in refugee camps. While only some community health volunteers will function also as human rights educators, all such volunteers should have a clear understanding of how human rights relate to malaria and to their functions as community health volunteers.
- Social and behavior change communication across a wide range of settings, including refugee camps, with some messages specifically targeting men
- Installation of window nets in prisons in counties with endemic or seasonal malaria; and
- Advocacy for improved malaria prevention (IRS, LLINs), diagnosis and treatment capacity in all correctional facilities.

Next Steps

Following from this baseline exercise, the Global Fund plans to engage with a range of country stakeholders working on these and other dimensions of health and human rights through a joint, multi-stakeholder meeting in Kenya. The baseline assessment will inform participatory processes in the frame of the Country Dialogue, to identify gaps and prioritize key interventions that can be included in the upcoming Funding Request.

2. Introduction

This report comprises the baseline assessment carried out in Kenya to support its efforts to scale-up programs to reduce human rights and gender-related barriers to HIV, TB and malaria services. Since the adoption of the *Strategy 2017-2022: Investing to End Epidemics*, the Global Fund has joined with country stakeholders, technical partners and other donors in a major effort to expand investment in programs to remove such barriers in national responses to HIV, TB and malaria. This effort is grounded in Strategic Objective 3 which commits the Global Fund to: “introduce and scale-up programs that remove human rights barriers to accessing HIV, TB and malaria services”; and, to “scale-up programs to support women and girls, including programs to advance sexual and reproductive health and rights and investing to reduce health inequities, including gender-related disparities” (The Global Fund, 2016). The Global Fund has recognized that programs to remove human rights and gender-related barriers are an essential means by which to increase the effectiveness of Global Fund grants as they help to ensure that health services reach those most affected by the three diseases. The Global Fund is working closely with countries, the Joint United Nations Program on HIV/AIDS (UNAIDS), World Health Organization (WHO), United Nations Development Program (UNDP), Stop TB, U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and other bilateral agencies and donors to operationalize this Strategic Objective.

Though the Global Fund will support all countries to scale-up programs to remove barriers to health services, it is providing intensive support in 20 countries in the context of its *Breaking Down Barriers* initiative and its corporate Key Performance Indicator (KPI) 9: “Reduce human rights barriers to services: # countries with comprehensive programs aimed at reducing human rights barriers to services in operation (The Global Fund, 2016).” This KPI measures, “the extent to which comprehensive programs are established to reduce human rights barriers to access with a focus on 15-20 priority countries.” “Comprehensive” programs are programs that: (a) comprise a set of activities that are internationally recognized as effective in reducing human rights-related barriers to health; (b) are accessible or serve the majority of the estimated numbers of key and vulnerable populations affected by such barriers; and (c) are adequately resourced to move from non-existence or one-off/small-scale activities to a level of implementation likely to significantly reduce human rights-related barriers to services (a sustained, mutually-reinforcing, broadly protective package at scale).⁹ Based on criteria that included needs, opportunities, capacities and partnerships in the country, the Global Fund selected Kenya, with 19 other countries,¹⁰ for intensive support to scale-up programs to reduce barriers to services. This baseline assessment for Kenya, focusing on HIV, TB and malaria is a component of the package of intensive support the country will receive.

⁹ This definition of “comprehensiveness” for the purpose of GF Key Performance Indicator 9 was developed with the Global Fund Human Rights Monitoring and Evaluation Technical Working Group.

¹⁰ The 20 countries are Benin, Botswana, Cameroon, Democratic Republic of Congo (province-level), Cote d'Ivoire, Ghana, Honduras, Indonesia (selected cities), Jamaica, Kenya, Kyrgyzstan, Nepal, Mozambique, Philippines, Senegal, Sierra Leone, South Africa, Tunisia, Uganda and Ukraine. https://www.theglobalfund.org/media/1213/humanrights_2016-removingbarrierspart2_ga_en.pdf

Purpose, Objective, and Expected Outcomes of the Baseline Assessment

The objectives of the baseline assessment are to:

- To define the nature and extent of human rights-related barriers to access, use, and retention in HIV, TB or malaria services in Kenya.
- To describe the mix of relevant programs, including their costs, either recently or currently being implemented, using:
 - the key human rights program areas in the context of HIV (UNAIDS, 2012b and 2020), (The Global Fund, 2017b)
 - the key human rights program areas in the context of TB (The Global Fund, 2017d), and
 - the key human rights program areas in the context of malaria (The Global Fund, 2017c).
- To propose a set of programs that would comprise a comprehensive response to removing human rights-related barriers, and analyse the capacity to implement/scale-up these programs to comprehensive level.

This assessment provides a baseline of the situation as of 2017¹¹ and will be followed up by assessments at mid- and end-points of the current Global Fund Strategy of the impact of the scale-up of programs to reduce human rights-related barriers.

The report is organized in the following sections: methodology; findings regarding the legal and policy environment; findings regarding the barriers to accessing services and existing programs in place to address human rights-related barriers for HIV, TB, and malaria; recommended programs for scale-up and their cost; and conclusions.

3. Methodology

Conceptual Framework and Program Areas

The conceptual framework that guided the assessment was as follows:

- In Kenya, as in other countries regionally and globally, there exist human rights and gender-related barriers to full access to, uptake of and retention in HIV, TB and malaria services.
- These barriers are experienced by certain key and vulnerable populations who are more vulnerable to and affected by HIV, TB and malaria than other groups in the general population.

¹¹ Although the Kenya baseline assessment was carried out in 2019, efforts were made to understand the situation in 2017. As of 2018, Kenya has accessed human rights matching funds. Hence, the baseline aims to capture the status preceding the 2018 increased funding for programs to reduce human rights-related barriers. Additional information from 2018 and 2019 was included, with the timeframe of implementation explicitly mentioned, with the purpose to inform the synthesis of the lessons learnt, and the new funding request.

- There are human rights-related program areas comprising interventions and activities that are effective in removing or reducing these barriers.
- If these interventions and activities are funded, implemented and taken to sufficient scale in the country, they will remove or significantly reduce these barriers.
- The removal of these barriers will increase access to, uptake of and retention in HIV, TB and malaria services and thereby accelerate country progress toward national, regional and global targets to significantly reduce or bring to an end the HIV, TB and malaria epidemics.
- These efforts to remove barriers will also protect and enhance Global Fund investments, and strengthen health and community systems.

The general categories of human rights-related barriers, as specified by the Global Fund, include those related to (a) stigma and discrimination; (b) punitive laws, policies, and practices; (c) gender inequality and gender-based violence; and (d) poverty and economic and social inequality.

There are seven key program areas comprising activities recognized as effective to remove human rights related barriers to HIV services, which are all also relevant in the context of TB (The Global Fund, 2017b). For HIV and TB these seven comprise:

- Stigma and discrimination reduction
- Training for health workers on human rights and medical ethics related to HIV and TB
- Sensitization of lawmakers and law enforcement agents
- Legal literacy (“know your rights”)
- HIV and TB-related legal services
- Monitoring and reforming laws, regulations, and policies related to HIV and TB; and
- Reducing discrimination against women in the context of HIV and HIV.

Additional program areas relevant to the removal of barriers in the context of TB include (The Global Fund, 2017d):

- Ensuring confidentiality and privacy
- Mobilizing and empowering patient and community groups; and
- Programs in prisons and other closed settings.

Program areas relevant to the removal of barriers in the context of malaria include (The Global Fund, 2017c):

- Human rights and gender assessments;
- Meaningful participation of affected populations;
- Strengthening of community systems for participation in malaria programs;
- Addressing gender-related vulnerabilities and barriers;
- Improving access to services for refugees and others affected by emergencies;
- Addressing malaria among people living with HIV; and
- Improved services in prison and pre-trial detention.

Assessment Process

(a) Desk Review

The desk review entailed literature searches, legal and policy environment data extraction and key informant interviews related to human rights barriers to accessing HIV, TB and malaria services in Kenya and programs to address these barriers. To identify relevant peer-reviewed literature, a comprehensive search was conducted using Google Scholar, PubMed, Popline, and Embase. Articles were initially selected for keywords in their abstracts and then further searched for relevance. Fifty peer reviewed articles and 200 pieces of 'grey literature' were ultimately selected for inclusion in the desk review. Data were extracted from a range of documents identified through a combination of Google searches as well as documents and reports recommended by Global Fund and key informants. Overall, 328 documents from the desk review, as well as documents received in-country, were reviewed in depth, including reports, newsletters and presentations (Annex 13-14).

(b) Preparation for In-country Research

Based on the desk review and discussions with the Global Fund and in-country partners, an initial list of key informants was identified prior to in-country work. This list was expanded over the course of data collection through consultations with stakeholders and key informants, with particular focus on the lived experience of impacted populations. Study instruments included adaptations of the Malaria MatchBox and previously used key informant interview and focus group discussion guides that were tailored to the Kenyan context with input from in-country partners and the Global Fund.

The study protocol and instruments were approved by institutional review boards (IRBs) in Kenya, the Kenya Medical Research Institute (KEMRI) (KEMRI/RES/7/3/1) and the United States, University of Southern California (#HS-18-00945). All members of the research team completed human subjects training as required by their local institution. Informed consent information sheets were professionally translated and back-translated from English to appropriate local languages: Ki-Swahili and Kamba.

(c) In-country Research

In April 2019, an inception meeting was held with approximately 45 national stakeholders and community members in Nairobi. In addition to discussing the baseline assessment and data collection procedures, and presenting the findings of the Kenya desk review, the meeting provided an opportunity to collect reactions, clarifications, and additional suggestions for further exploration during in-country work, including additional potential key informants and relevant programs. During this meeting, participants expressed the need for inclusion of rural communities in field work given that a large proportion of the Kenyan population resides in rural areas where barriers to accessing services (and the programs to overcome them) are quite different than in urban areas. For this reason, the scope of in-country data collection was

expanded to include Kitui County¹². The need to also collect data on human rights-related barriers to accessing services experienced by older women living with HIV and indigenous populations was also expressed, and data collection plans were adapted accordingly.

Following the inception meeting, a team of researchers conducted interviews with key informants and focus group discussions, with a focus on key and vulnerable populations. In Nairobi, interviews were used primarily to gather national-level data, and in Mombasa, Kisumu, and Kitui, to gather county- and local-level data. The purpose of the in-country data collection was to deepen understanding of the most urgent and important barriers to accessing HIV, TB and malaria services in Kenya, to learn about the most effective programs to date, to inform what it would take to put in place a comprehensive approach by which to remove these barriers, and to collect data as the basis for calculating the unit costs of different programs and a comprehensive approach.

(d) In-country Interviews

In-country data collection consisted of key informant interviews with key stakeholders including persons affected by the diseases and focus group discussions with representatives of relevant key and vulnerable populations for HIV, TB and malaria. Informed consent information sheets were provided to participants in English, Kiswahili or Kamba, as appropriate, and consent was obtained by trained staff prior to the start of data collection. In total, the research team carried out 83 in-country interviews (64 key informant interviews and 18 focus group discussions) with approximately 174 participants (64 key informant interviews and 110 focus group discussion participants), and four telephone interviews. Interview participants represented a range of groups and entities including NGOs, affected communities, government agencies, hospitals, and research institutions (Annex 12). In-country focus group discussions were carried out with female sex workers, men who have sex with men, transgender individuals, people living with HIV, people who use drugs, young women and mothers of young children. All of this resulted in the collection of significant information about barriers, and existing programs. Data were collected on:

- Human rights-related barriers to HIV, TB and malaria services;
- Key and vulnerable populations most affected by these barriers;
- Current or recent programs that have been found, through either evaluation or consensus among key informants, to be effective in reducing these barriers;
- Funding for all such programs as available;
- Retrospective costing of programs shown to be effective as available; and
- Gaps and recommendations regarding what is needed to comprehensively address the most significant barriers for groups most affected by these barriers.

¹² An amendment to the study IRB approvals had to be sought to expand the study area into Kitui. This led to substantial delays so while fieldwork was carried out in Nairobi, Kisumu and Mombasa in April 2019, data collection in Kitui took place in January 2020.

(e) Program Costing

A retrospective analysis of funding for human rights programs to address HIV, TB and malaria in 2017 is included. The prospective costing will be carried out once the comprehensive package of programs to address human rights barriers to accessing HIV, TB and malaria services has been agreed on.

(f) Data Analysis

The detailed notes from the in-country data collection were synthesized and analyzed together with the desk review findings. This synthesis established a baseline understanding of the barriers that many populations face in accessing and using HIV, TB and malaria services in Kenya, and reflects, to the extent possible, the strengths and gaps of existing programming to address these barriers. Building on this analysis, a description of a comprehensive response was developed. This description includes programs that should be scaled-up and programs that should be added.

(g) Validation and Next Steps

There was follow-up communication with a range of key informants to ensure correct understanding of information they had provided or to seek additional details. Many key informants were responsive to these requests; a few did not respond, which has left some gaps in information.

A few weeks after completion of the initial fieldwork, a conference call was set up with the core group of the Country Coordinating Mechanism to update them on study progress. Regular updates were provided to the Global Fund throughout the processes of data collection and analysis.

As a draft, this report will be shared extensively with a broad range of partners and community members for input. A joint, multi-stakeholder meeting convened by the Global Fund will represent an opportunity to engage with a range of country stakeholders working on these and other dimensions of health and human rights to discuss and vet findings on what is already being supported, what gaps exist, and where there are opportunities to fund and implement these or other recommendations in order to make the response to human rights-related barriers to HIV, TB and malaria services comprehensive. It is expected that the baseline assessment will inform the country dialogue for the development of the new Funding Request.

4. Baseline Findings – Legal and Policy Environment

This section of the report focuses on the legislative environment in Kenya as it pertains to potentially protective laws relevant to key and vulnerable populations, regardless of health status, as well as key elements of national policy that are most relevant to HIV, TB and malaria. Descriptions of HIV, TB, and malaria specific laws and policies that apply broadly across key and vulnerable populations, as well as legal and policy barriers to services, are included separately in respective sections below.

International Human Rights Commitments

Kenya has ratified a number of international laws and conventions relating to key populations and vulnerable groups in the context of HIV, TB, and malaria, including the International Covenant on Civil and Political Rights (ICCPR); the International Covenant on Economic, Social, and Cultural Rights (ICESCR); the African Charter on Human and Peoples' Rights; the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW); the Convention on the Rights of the Child (CRC); the Convention on the Rights of Persons with Disabilities; and the Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment (FIDA Kenya, 2008). These treaties were incorporated into Kenyan law by the 2010 Constitution, operationalizing the government's stated commitment to promote and protect these rights (KELIN, 2012a).

African regional laws also reiterate these international human rights law standards and address the right to health in general. For example, the African Charter on Human and Peoples' Rights seeks to ensure that every individual can attain the highest standard of physical and mental health. The Charter obligates states parties to "protect the health of their people" and provide medical attention to those who need it (African Commission on Human and Peoples' Rights, 1979; KELIN, 2018i). Other relevant commitments at the continental level include, among others, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (that covers sexual and reproductive health as well as comprehensive sexuality education), and the African Commission on Human and Peoples' Rights' Resolution 275 on the "protection "against violence and other human rights violations against persons on the basis of their real or imputed sexual orientation or gender identity" (ACHPR, 2014).

The rights of people living with or at risk of HIV, TB or malaria can be protected under many international legal instruments. A selection of these rights which are protected under international human rights law are included in Annex 1.

Legal System and General Laws and Policies

The Kenyan legal system is primarily based on English common law, although it also incorporates elements of Islamic and customary law (CIA, 2019). Currently, there is one national government and 47 county governments. The 2010 Constitution is the supreme law of the republic, setting the standards to which all laws, policies, and guidelines must conform. The legal system also incorporates international law, legislation enacted by the National Assembly and Senate, and legislation enacted by county assemblies.

The Bill of Rights in the Constitution protects and guarantees civil and political rights and socioeconomic rights. The language of the Constitution recognizes these rights as an “integral” part of good governance and democracy (National Council for Law Reporting, 2010), echoing international commitments to the promotion and protection of the human rights of each individual (KELIN, 2012a; National Council for Law Reporting, 2010). Article 43(1) specifically provides for the “right to the highest attainable standard of health,” which includes the “right to health care services, including reproductive health.” Additionally, the Constitution ensures the rights to life, equality and non-discrimination, human dignity, and privacy (National Council for Law Reporting, 2010; Reporting, 2010).

The 2010 Constitution introduced additional checks on presidential authority and reorganized the country into 47 counties with greater independence from the central government, essentially devolving power. Under the new constitution, Kenya is primarily governed first at the national level by the executive branch (the president and the cabinet), the legislative branch (the National Assembly and the Senate), and an independent judiciary. The main unit of subnational government occurs at the county level, where each of the 47 counties is semi-autonomous. The county level government has an executive arm (the governor and the county executives/cabinet) and a legislative arm (the county assembly), and is responsible for implementing national level legislation, but also developing and implementing county level laws and policies as needed (Constitution of Kenya 2010). The national and county level governments are distinct and interdependent; mutual relations should be conducted on the basis of consultation and co-operation (Constitution of Kenya 2010).

Health is a devolved function with the Fourth Schedule of the Constitution assigning the national government the function of developing national health policies and managing national referral health facilities. County governments are assigned the bulk of functions in relation to health service delivery as they are responsible for provision of county health services including managing county health facilities and pharmacies, ambulance services, and promotion of primary health care, among others.¹³ The county level can be a good platform for pressing for legal and practice reforms in the respective counties: strategic partnerships and advocacy toward county assemblies and county executive can result in legal and practice reforms. The Kenya Health Policy 2014-2030 describes the structure of the integrated, six-tiered health service delivery system (Ministry of Health, 2014b). In terms of policy, the national level is responsible

¹³ The other health-related functions as listed under the Fourth Schedule to the Constitution include licensing and control of undertakings that sell food to the public; veterinary services; cemeteries, funeral parlours and crematoria; and refuse removal, refuse dumps and solid waste disposal.

for health policy – and as such, the national level is still the best avenue to be targeted for policy reform.

The Ministry of Health (MOH) released the National Patients Charter in 2013, which enumerates the rights of patients in conformity to international human rights standards, including the rights to access healthcare, receive emergency treatment, information, choice of health care provider, highest attainable standard of health, refusal of treatment, privacy, confidentiality, respect and dignity, second medical opinion, complaint and consent among other. The Charter also contains patient responsibilities and rules for dispute resolution. All the rights contained in the Charter stem from the Constitution and are therefore enforceable in a court of law (KELIN, 2018f; Ministry of Health, 2013). However, no analysis was found of the extent to which the Patients Charter has been enforced, and anecdotal reports suggest that community awareness of the National Patients Charter and the rights that patients have remains low.

In 2014, the MOH published the Kenya Health Policy 2014-2030, which outlined a methodology for attaining and actualizing the “highest possible standard of health in a responsive manner” for all Kenyans. The Policy states that the health sector will employ a “human rights-based approach in healthcare delivery and will integrate human rights norms and principles in the design, implementation, monitoring, and evaluation of health interventions and programs.” The Policy also set forth six policy objectives, which included the elimination of communicable diseases, and eight orientations to define the structures needed to fulfill the objectives and achieve the overall policy goal (Ministry of Health, 2014b).

In 2017, the Health Act was enacted to give teeth to the provisions of the Constitution guaranteeing the right to the highest attainable standard of health. This right encompasses the rights to emergency medical treatment, information, informed consent, and confidentiality (The Health Act No.21 of 2017, 2017). The Act pays special attention to the rights of vulnerable groups, which include women, the elderly, persons with disabilities, children and youth, members of minority or marginalized communities, and members of particular ethnic, religious, or cultural communities (The Health Act No.21 of 2017, 2017), (Kenya Gazette Supplement, 2017). It “places dignity, respect and privacy as the core to the realization of the right to health”. It also specifies laws around maternal and child health while effectively mandating the provision of free maternal and child health services (Oduor, 2018).

Reference to Key Populations in Specific Laws

In addition to the broadly protective laws described above, there are a range of provisions that confer protections to particular population groups, including some of the key and vulnerable populations listed in the introductory section above. However, despite these protections and those guaranteed by the Constitution and Kenya’s international human rights commitments, a number of domestic laws single out key populations by limiting their access to legal protections, access to health services, and freedom from discrimination. These provisions, which exist at national and county levels, effectively create barriers for these groups and expose the existing

gaps and hurdles that must be overcome in the country's responses to HIV, TB, and malaria. Relevant laws intended to protect vulnerable populations are set forth below (see also Annex 2).

Persons with Mental Disabilities - Section 19 of the Sexual Offences Act prohibits prostitution of person with mental disabilities. This provision seeks to protect persons with mental disabilities preventing their exposure to prostitution and consequently HIV and other health issues.

Children - Section 14, 15 and 16 of the Sexual Offences Act, 2006, prohibit the involvement of children in sex tourism, prostitution and pornography, respectively. Section 15 of the Children Act, 2001 also protects children from sexual exploitation, stating: "A child shall be protected from sexual exploitation and use in prostitution, inducement or coercion to engage in any sexual activity, and exposure to obscene materials".

Sections 3, 4, 5 and 9, of the Children Act, 2001, also calls for the progressive realization of children's rights, ensuring that their "best interest" as a prime consideration, and ensuring non-discrimination and their right to health care. With regard to these legal protections, researchers note that principles of non-discrimination and protection from abuse help to ensure children who are living with HIV are able to access health services without facing barriers. They further note, by contrast, that "stigma-related experiences like social rejection, discrimination, and physical violence increase the risk for psychological problems among HIV-infected individuals, which may also hamper treatment behaviors." (McHenry et al., 2017)

The Children Act, 2001, in Section 14, also calls for the protection of a child from harmful cultural practices such as female genital cutting, early marriage or anything else that can affect the child. This provision specifically provides for protection of children from early marriage when such a practice can affect the child. (Girls Not Brides, 2018b) It is well established that child brides face challenges negotiating safe sex, avoiding early pregnancy or accessing health services including for sexual and reproductive health and HIV. (Girls Not Brides, 2018a). Notably, Kenya has committed to ending child marriage by the end of 2020 (UNESCO, 2013).

Marriage – Sections 4 and 13 of the Matrimonial Property Act, 2013 give equal rights to matrimonial property to both spouses, which enables women to be financially independent of their male counterparts and can prevent them from engaging in precarious work such as sex work. (Human Rights Watch, 2003). Section 4 of the Marriage Act, 2014 sets the minimum age of marriage as 18, with no exceptions. Sections 45 (3a), (3b) and (3c) of this Act further confirm that if a marriage is completed as per customary law, it should be between parties who are at least 18 years old, between person who are not prohibited to marry, and through free consent of the parties. The law prioritizes age of marriage and consent over culture or tradition, thereby nullifying any forced marriage of an underage girl. However, despite these strict, bright-line provisions, child marriage remains prevalent in Kenya. (Girls Not Brides, 2018b)

People who use Drugs – Section 29 of the Pharmacy and Poisons Act, 1989 prohibits the sale of poisons (drugs) except on a prescription by a medical practitioner, veterinarian or dentist. While intended to be protective and regulating the sale of drugs on prescription can help to curb

misuse. this law can be misapplied to deny sale of clean needles/syringes, leading to a failure of harm reduction efforts. (Mainline, 2015)

Access to Treatment - Rule 6 of the Pharmacy and Poisons (Registration of Drugs) Rules, under the Pharmacy and Poisons Act, 1989, requires that prior to drug registration, the Pharmacy and Poisons Board must certify its safety, efficacy, quality and economic value. In other words, as long as any new drug meets the criteria under this rule, it can be registered and be used for treatment. The Act thus makes the drug registration process faster and more effective. The act also establishes the Pharmacy and Poisons Board which oversees the registration of pharmacies and new drugs.

Laws and policies that constitute barriers to services, organized by the primary affected population, can be found in the baseline findings for the specific disease areas, as well as in Annexes 3-6. HIV, TB, and malaria-specific laws that apply broadly across key and vulnerable populations are discussed below and included separately in Annexes 7-8 (HIV), 9-10 (TB) and 11 (malaria).

Access to Justice

The Kenya National Human Rights and Equality Commission and National Gender Equality Commission were established under the Constitution to ensure reporting and redressal of any case of discrimination (KELIN, 2010).

Litigation is a costly process placing an extreme burden on an individual's financial and other resources. This is particularly true for individuals struggling with health concerns like HIV, TB, or malaria.

The 2016 Legal Aid Act seeks to provide access to legal representation and counsel to every "indigent person," which has been defined as any Kenyan citizen, child, refugee, victim of human trafficking, internally displaced or stateless person who cannot afford legal services. Legal representation can be made available for civil, criminal, constitutional, or public interest matters. The Act also established the National Legal Aid Service, which rules on a person's indigent status and his or her eligibility for legal aid.

Building on the Legal Aid Act and National Legal Aid and Awareness Program and in partnership with the International Development Law Organization, the Kenyan government launched the National Plan on Legal Aid 2017-2022 (Office of the Attorney General and Department of Justice, 2017). The Plan establishes the policy and institutional framework for improving access to justice, and specifically makes it easier for people living in poverty and those falling within specific areas of focus, including women, children and persons with disability, to access justice through legal aid. (IDLO, 2017). The Plan also seeks to "promote legal awareness" and "provide support to community legal services by funding justice advisory centers and promoting alternative and traditional dispute resolution methods" (IDLO, 2017).

If the National Plan on Legal Aid is implemented, then the country will have a well-educated, empowered community making choices about their rights and responsibilities, demanding justice, accountability and effective remedies across the board. This is the whole essence of access to justice (IDLO, 2017). However, no evidence could be found of any cases relating to HIV, TB or key or vulnerable populations whose rights had been violated being picked up through this mechanism. Awareness of the program remains low, and there has been a lack of outreach to people living with HIV, people with TB or other key or vulnerable populations to offer any services.

5. Baseline Findings – Health System

This section provides a very brief overview of the health system in Kenya to contextualize the findings and recommendations of this report.

The health system in Kenya has been shaped by the legal framework of the 2010 Constitution and guided by the objectives of Vision 2030, Kenya Health Policy 2014-2030 (Ministry of Health, 2014b), Kenya Health Sector Strategic and Investment Plan 2014-2018 (Ministry of Health, 2014d) and global development commitments. The 2010 Constitution adopted an explicitly rights-based approach based on the obligations of duty bearers and understanding people to be rights holders in conformity with international human rights law standards.

Health insurance coverage through the National Hospital Insurance Fund (NHIF) is low at 19%, which leads to high out of pocket costs on health spending for most individuals (Kenya National Bureau of Statistics, 2015b; Statistics., 2015). In 2014, 39% of people in the highest wealth quintile had health insurance compared with only 4% in the lowest wealth quintile (Kazungu & Barasa, 2017). Although people in informal employment constitute 83% of the total workforce (The World Bank, 2016), only 24% of people enrolled in the NHIF are in informal employment (Kenya National Bureau of Statistics, 2016).

The NHIF claims “No exclusions for all medical conditions except cosmetic procedures” and includes the chronic management of HIV/AIDS (NHIF, 2019c). There are numerous service schemes available for various demographics and needs. NHIF has an initiative to provide health services to pregnant women and infants at little or no cost including malaria prophylaxis, as well as HIV and TB screening and treatment (NHIF, 2019a). To note, there are numerous outpatient NHIF health centers and facilities available under some schemes in project areas with 39 in Kisumu county, 20 in Mombasa county and 124 in Nairobi county (NHIF, 2019b).

In 2014, Kenya reached lower middle-income status, and with that, donor support for the health sector is declining. For this reason, domestic resource mobilization has been prioritized as part of new strategic plans to ensure the health sector is adequately supported (Ministry of Health, 2019).

Universal Health Coverage

In 2017, as part of the Big Four Action Plan, the government of Kenya announced its aim to achieve universal health coverage (UHC) through a scale-up of uptake of National Hospital Insurance Fund (NHIF) over the next five years. Goals of the program include 100% coverage for essential health services as well as 54% reduction (as a percentage of household expenditure) in out-of-pocket medical expenses (The Executive Office of the President, 2018). There is a need for coordination between the county and national level to scale-up these efforts. There has also been a call for partnerships with the private sector, civil society and NGOs to build programming (Vision2030, 2018). A pilot test of the UHC plan began in December 2018 in four counties – Kisumu, Isiolo, Machakos and Nyeri – ahead of the planned national roll out (WHO Africa, 2018). Data is not yet available regarding the success of this pilot test. Identifying and addressing human rights barriers to accessing health services can therefore help contribute to the Presidential priority initiative of universal health care. Furthermore, integrating work to address human rights barriers to HIV, TB and malaria services into UHC can help ensure integration and sustainable funding over time.

6. Baseline Findings – HIV

This section of the report focuses on findings relevant to HIV including the epidemiological context, political and legal environment, barriers to accessing services, and existing programs in place to address human rights-related barriers to HIV accessing services.

HIV Epidemiology

(a) General

UNAIDS estimates 860,000 women and 520,000 men over the age of 15 were living with HIV in Kenya in 2017. Among adults aged 15-49, HIV prevalence was estimated at 6.2% among females and 3.5% among males (UNAIDS, 2018). In 2017, UNAIDS estimated 18,000 young people age 15-24 were living with HIV in Kenya. HIV prevalence among young women age 15-24 was double that of young men at 2.6% and 1.3%, respectively (UNAIDS, 2018). Since 2010, there has been a 32% decline in new infections and a 48% decline in acquired immunodeficiency syndrome (AIDS)-related deaths in Kenya (UNAIDS, 2018). Since 2010, the coverage of people receiving antiretroviral therapy (ART) has more than doubled; it was estimated at 75% in 2017 (UNAIDS, 2018).

There were 110,000 children aged 0-14 living with HIV in Kenya in 2017, 82% of whom were on ART. 8,000 children aged 0-14 were infected with HIV the same year and there were an estimated 4,300 AIDS-related deaths among children under the age of 14 (UNAIDS, 2018).

(b) Key Populations

Population size estimates have been carried out for females who engage in sex work, men who have sex with men, people who inject drugs, and transgender people. These estimates are critical for informing programming. Based on the mapped counties, the estimated population sizes are: 167,940 female sex workers, 32,580 men who have sex with men, 16,063 people who inject drugs, and 4,305 transgender people. Some people may belong to more than one key population e.g. 36% of the men who have sex with men also identified as male sex workers. The highest concentration of 'hotspots' where key populations congregate is in Nairobi (NAS COP, 2018).

A 2010-2011 study found HIV prevalence among men who have sex with men in the study to be 18.2% in Nairobi and 11.1% in Kisumu (National AIDS and STI Control Program, 2014). HIV prevalence among people who use drugs in Nairobi is estimated at 18.7% (National AIDS and STI Control Program, 2014). HIV prevalence among females who engage in sex work in Nairobi is estimated at 29.3% (National AIDS and STI Control Program, 2014), and among males who

engage in sex work in Nairobi, it is 40% (McKinnon et al., 2014). A 2012/2013 survey was conducted at Kamiti and Kang'ata prisons among 142 adult male and female inmates; 56% of study participants self-reported positive HIV status with prevalence reported to be higher among men than women (Wanjiku Musili & N. Mbatia, 2016).

Kenya recently reported ART coverage of 76%, 65%, and 68% among female sex workers, men who have sex with men, and people who use drugs respectively (National AIDS Control Council, 2018).

Very little data on mobile populations was gleaned through this assessment, not only in the context of HIV but also TB and malaria. The same is also true for prisoners and incarcerated populations, particularly around the issues of seroconversions within prison and loss to follow-up during transfers back to the community. Data gaps have also been noted in relation to LGBT populations in rural areas and those of school-going age (Iranti, 2019).

Global Commitments

Kenya has made a commitment to the key programs for HIV as expressed in the 2011 *Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS* and 2016 *Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030* (United Nations General Assembly, 2011, 2016). Kenya also plays a driving role in the Global HIV Prevention Coalition, including co-convening a side event at the 2018 World Health Assembly on 'Towards Universal Coverage with HIV Prevention Services and Commodities – the Global Prevention Coalition and Roadmap' (WHO, 2018a).

Protective Laws and Policies Relevant to Access HIV Services

(a) National Strategy

The national HIV response in Kenya is led by the National AIDS Control Council (NACC) and National HIV/AIDS and STD Control Program (NAS COP). NACC is responsible for the formulation of strategies for care and support of people living with HIV as well as the mobilization and coordination of resources for HIV prevention. It also convenes a technical working group on HIV, human rights and the law. NAS COP is responsible for the biomedical and structural interventions of Kenya's HIV response. NACC's Kenya AIDS Strategic Framework 2014-2019 (KASF) identified four main objectives to be achieved by 2030: "(i) reduce new infections by 75%, (ii) reduce AIDS related mortality by 25%, (iii) reduce HIV related stigma and discrimination by 50%, and (iv) increase domestic financing of the HIV response to 50%." These objectives are to be delivered through strategic directions including "Using a human rights approach to facilitate access to services for people living with HIV (PLHIV), key

populations and other priority groups in all sectors” (Ministry of Health, 2014a). The priority areas attached to this strategic objective are:

- “Remove barriers to access of HIV, sexual and reproductive health (SRH) and rights information and services in public and private entities
- Improve National and County legal and policy environment for protection of priority and key populations and people living with HIV
- Improve access to legal and social justice and protection from stigma and discrimination in the public and private sector
- Using Human rights approach to assist programs to pursue zero tolerance to stigma and discrimination” (Ministry of Health, 2014a).

The KASF also states that gender and human rights should be mainstreamed in all aspects of the response planning and service delivery. Its objectives focus on reducing HIV incidence, AIDS-related mortality and HIV-related stigma, and increasing domestic funding for the HIV response (Ministry of Health, 2014a). HIV policies and strategies are also developed at the county level. All of the 47 county governments have HIV and AIDS strategic plans, largely taking the form and shape of the KASF. Therefore, all 47 counties have a strategic objective that focuses on using a human rights-based approach to facilitate access to services.

KASF II, to cover 2020/1-2024/5, is under development at the time of writing this report. Under the overarching goal of contributing to attainment of Universal Health Coverage through comprehensive HIV prevention, treatment and care for all Kenyans, its stated objectives are:

- i. Reduce new HIV infections by 75%
- ii. Reduce AIDS related mortality by 55%
- iii. Reduce HIV related stigma and discrimination to 25%
- iv. Increase domestic financing of the HIV response to 50%

‘Respect for human rights’ is the first listed guiding principle of the strategic framework (NACC, 2020).

The provision of antiretroviral therapy services in Kenya is guided by the constitution that provides for the right to quality health care services to every citizen.

(b) Laws

The East African Legislative Assembly (EALA) passed the East African Community HIV and AIDS Prevention and Management Act 2012, a regional HIV law aimed at promoting effective HIV responses. Kenya has ratified the Act and is bound by the Act such that its provisions should supersede inconsistent national HIV laws. The Act seeks to bring about legal and policy change, uphold principles of non-discrimination and access to healthcare and information for

people living with HIV and key populations, prevent violence toward people living with HIV, and enforce constitutional and international guarantees (KELIN, 2012b).

The national and sub-national legislation most relevant to HIV, as well as county-level legislation (in Kisumu, Mombasa, and Nairobi), are outlined below, as well as in Annex 7.

The HIV and AIDS Prevention and Control Act is the primary HIV-specific law in Kenya. It contains a range of essential protections for people living with and affected by HIV. For example, sections 14 and 22 of the Act ensure consent to HIV testing and disclosure of HIV status, as well as privacy of test results. Sections 18, 20 and 21 similarly protect the confidentiality and privacy of a person's test results, HIV status and medical records, and Section 23 makes any breach of these protective provisions an offense. Confidentiality and privacy are essential in the context of HIV. When a health care worker reveals a person's HIV status without his or her consent, it is a clear breach of privacy; thus making this protection essential. Additionally, there is an association between breaches of the right to privacy and stigma and gender-based violence. (KELIN, 2014d)

Sections 4, 5, 6, 7 and 8 of the Act call for the provision of HIV and AIDS information and education through public campaigns, by healthcare service providers, at workplace and institutions of learning. These provisions address the reality that HIV and AIDS education and information are key to prevention and control.

Section 13 of the Act prohibits compulsory testing and HIV test as a precondition for employment, marriage, admission, travel, access to health services and insurance cover. Section 14 specifically calls for informed consent to HIV testing. These provisions seek to prevent forced HIV testing and ensure that informed consent is required for HIV testing.

Sections 15, 16, 17 and 19 of the Act address the availability of HIV testing centers and counseling and access to healthcare services and specifically call for making testing centers available for safe HIV testing with pre- and post-test counseling services. These provisions operationalize counseling as a cornerstone of the HIV response. Counselling also provides useful information and can be an entry point into appropriate prevention, care and treatment services. It also helps to prevent misinformation and stigma around HIV. While access to safe HIV testing and healthcare services is important for everyone, it is particularly important to marginalized individuals and groups.

Sections 31-38 of the Act prohibit HIV-related discrimination in workplace, schools, traveling and habitation, public service, insurance services, health institutions and for burial. These provisions confirm that violation of these provisions constitute an offence under the Act, for engaging in discrimination against people living with HIV.

Finally, sections 25-30 of the Act, establish and set forth the procedural rules for the HIV/AIDS Tribunal. This Tribunal was established to improve access to the courts and litigation for matters involving people living with HIV and their family members. The tribunal has the jurisdiction to adjudicate on matters stated under the Act. It aims to resolve disputes involving forced testing,

discrimination, and denial of access to health and other services. In short, the tribunal aims to overcome challenges faced by key populations accessing the courts and consequently justice.

While the Tribunal was slow to become operational and there have been achievements including a range of cases that have been successfully adjudicated, challenges remain which hinder its effectiveness and threaten to compromise the realization of its objectives. “These challenges are multi-faceted and relate to structural, financial, and operational issues. In addition, the limited public awareness of the tribunal remains a concern.” (Eba, 2016). The Ministry of Health itself has acknowledged that the Tribunal mechanism may be underutilized by the general population in part due to limited understanding of its existence and mandate and in part due to its centralized location in Nairobi (Ministry of Health, 2014a). A key informant from Nairobi indicated there is a gap in that the HIV and AIDS Tribunal pre-dates devolution and there is a need to provide for Tribunal services in the counties (key informant interview 35).

Cultural and Social Environment Relevant to Access HIV Services

In-country interviews revealed a number of cultural and social elements that impact access to HIV services, both in regard to perceptions of HIV itself, but also key and vulnerable populations most affected. From a cultural perspective, the behaviors of many key and vulnerable populations (such as sex between men, sex work and drug use) are reportedly not accepted by the majority (key informant interview 35, key informant interview 81). There were reports of cultural misconceptions around HIV. For example, a key informant in Mombasa reported that some hold the belief that people living with HIV are bewitched or that HIV is hereditary (key informant interview 10). A key informant from Kitui reported community beliefs in witchcraft, indicating that some people living with HIV reportedly believe they have been bewitched and if they visit a health facility, they will bring back more of the virus. In addition, they noted widows are accused of bewitching their husbands and causing their death (key informant interview 81).

Key informants across different groups and regions reported that religion and religious leaders play a role in a community’s perceptions and beliefs around HIV and key and vulnerable populations (key informant interviews 52, 25, 32, 36, 22, 14, 81, 79). Though a number of faith based organizations are working to support those affected by HIV, a key informant reported that the majority of religious leaders in Kitui encourage stigma, and noted that more progressive religious leaders have been repressed and/or have less influence (key informant interview 81). A key informant from Nairobi reported that the community is scared and believes HIV is a sin (key informant interview 52). This highlights the heterogeneity of the religious community with some people within it creating barriers to accessing HIV services and others doing invaluable work to provide programs and services. Both aspects, as they arose in key informant interviews are covered under the respective barriers and programs below.

Barriers are reportedly worse in rural areas where myths and misconceptions from religious influence are more common (key informant interview 12). Some religious leaders reportedly hold traditional beliefs and encourage the use of herbs rather than drugs (key informant interview

81). There are also reports of religious leaders advocating for people adhering to prayer rather than treatment with antiretrovirals (ARVs) (key informant interview 40, focus group discussion 10). In Kitui, informants reported the existence of religious cults that prevent people from accessing medical services (key informant interview 14, focus group discussion 14). A key informant from Mombasa reported that religious communities oppose needle exchange and there have been instances of mob justice (key informant interview 6).

One interview participant suggested that the recent focus of the national HIV response on key populations, in their view almost to the exclusion of attention to the general population, has served to increase negative attitudes toward key populations (key informant interview 25).

Human Rights-related Barriers to HIV Services

This section of the report focuses on specific barriers experienced by relevant key and vulnerable populations in accessing HIV services. Broadly these barriers include: punitive laws, policies and practices; stigma and discrimination; gender inequality and gender-based violence; poverty and economic and social inequality, as well as barriers concerning insufficient availability and accessibility of services and government and health service coordination. Each subsection below includes a descriptive analysis of the nature and direct and indirect impacts of barriers in the context of HIV.

Some informants reported that the language of human rights was itself a barrier to creating buy-in to activities, with some stakeholders reacting negatively to this framework. (key informant interviews 17, 34).

(a) Punitive Laws, Policies and Practices

Despite the strong national and international legal frameworks and commitments to the protection of human rights, Kenya still faces challenges. Many key populations, such as men who have sex with men, transgender people and people who engage in sex work, have been denied access to health services by health workers, a violation of the Constitution and Kenya's obligations under the International Covenant on Economic, Social and Cultural Rights (ICESCR). Additional concerns have been raised, for example, over instances of mandatory pre-marital HIV testing (Open Society Institute, 2010) and involuntary sterilization of people living with HIV (African Commission on Human & Peoples' Rights, 2018; UN, 1984a). The African Commission on Human and Peoples' Rights has even issued a resolution against involuntary sterilization of women living with HIV (ACHPR, 2013). Despite, this, it appears that involuntary sterilizations continue in Kenya, especially in rural areas. KELIN notes that despite the Kenyan government's public condemnation of the practice, it "has never made any effort to prevent doctors from committing this blatant infringement on women's autonomy." (Saoyo, 2016) In 2014, the organization initiated litigation on behalf of women who were involuntarily

sterilized, and recently, in January 2020, the High Court confirmed that it will hear some of those cases in the coming months.

The criminalization of same-sex conduct and overly broad laws around HIV criminalization have been found to increase vulnerability, undermine trust in health services and create barriers to accessing services for marginalized groups including men who have sex with men, transgender people and people who engage in sex work (African Commission on Human & Peoples' Rights, 2018; Kenya Human Rights Commission, 2017) .

There have been recent efforts to sensitize police and health workers to human rights concerns in relation to HIV, but high staff turnover due to rotation policies has been a challenge to these efforts to build capacity (key informant interview 26).

An overview of punitive laws, policies and practices affecting different populations is presented below by the population affected.

(b) People Living with HIV

(i) Laws criminalizing HIV transmission

Section 26 of the Sexual Offences Act explicitly criminalizes transmission of HIV and other STDs. Section 26(1) makes punishable by imprisonment for 15 years (which can be extended to a life term), any person who knows their HIV status and knowingly: infects another person with HIV or other life-threatening STD; is likely to infect another person with HIV or other life-threatening STD; infects another person with an STD. This provision applies to all people, including married couples. In cases where individuals are accused of violating Section 26(1), Courts are permitted to order samples to be taken to ascertain the accused's HIV status, pursuant to Section 26(2) of the Act.

The following concerns have been raised about Section 26:

The implications and extent of Section 26 of the Sexual Offences Act are far-reaching given that any person who has potentially put the other at risk of contracting the virus can be prosecuted, irrespective of whether or not transmission occurred. A married person can even be prosecuted for engaging in sexual activity with their own spouse. (KELIN, 2014b) Article 26 also appears to discriminate against people living with HIV, women, and vulnerable people, and violates a number of fundamental human rights. For example, the law increases the probability of prosecuting women because conviction requires proof that the accused knew their status and women know their status at far higher rates than men. Additionally, the laws disincentivize HIV testing, as knowledge of one's status renders them vulnerable to prosecution. (KELIN, 2018d)

Some report that the "prosecuting authority's interpretation of Section 26 of the Sexual Offences Act, as demonstrated by the prosecutions of several of the people living with HIV challenging the law, effectively makes it a crime for a woman with HIV to birth and raise children. The prevailing interpretation of the law also effectively criminalizes marriage between a person who has HIV and a person who does not. (KELIN, 2018d)

Section 26 of the Sexual Offences Act continues to be used as the basis for prosecuting people who are suspected of exposing others to HIV. Many of the recent cases have involved breastfeeding.¹⁴

Section 26(7) of the Sexual Offences Act, 2006 explicitly precludes people prosecuted under Section 26(1) for infecting or having the likelihood of infecting another with HIV or other STDs from filing any claim against the state, any minister or a medical practitioner in a court of law.

This provision effectively protects the State, all ministers and medical practitioners from any liability for wrongful prosecution or harassment of people living with HIV or other people (KELIN, 2014c), and impedes access to justice.

There is no evidence to prove that criminalization actually reduces HIV transmission. Rather, it pushes people away from seeking HIV testing and treatment. Criminalization also contributes to the stigma and discrimination surrounding a person's HIV status (KELIN, 2018c).

(ii) Laws governing disclosure of HIV status

Section 24 of the HIV and AIDS Prevention and Control Act, 2006, covers disclosure of HIV status. In 2015, the High Court of Kenya held that a person with whom a person living with HIV shares their HIV status has no obligation to not disclose this status, and in the absence of any law preventing this breach of privacy for people living with HIV, Section 24 appears to contravene Article 31 of the Constitution (Oxford Human Rights Hub, 2015). A key informant noted the need to align the Act with the Constitution by reviewing each provision and repealing them where necessary as with Section 24 (key informant interview35).

Section 43(3)(c) of the Sexual Offences Act confirms that one engages in an intentional and unlawful act if the act is committed under "false pretenses or by fraudulent means"; the definition of which includes "intentionally fail[ing] to disclose to the person in respect of whom an act is being committed, that he or she is infected by HIV or any other life threatening sexually transmittable disease." (KELIN, 2014b) Thus, this provision appears to criminalize the non-disclosure of HIV status, despite constitutional protections and jurisprudence. Section 43(3)(c) of the SOA is commonly enforced specially to enhance sentences in sexual offences cases involving rape, and defilement.¹⁵ This law has not been challenged before a court of law.

¹⁴ See, for example, <https://nairobi.news.nation.co.ke/news/maid-in-court-for-infecting-employers-baby-with-hiv-through-breastfeeding>; <http://www.hivjustice.net/storify/kenya-29-year-old-woman-arrested-and-charged-with-alleged-intentional-transmission-for-breastfeeding-a-baby/>; <http://www.hivjustice.net/storify/kenya-woman-living-with-hiv-arrested-for-breastfeeding-baby-in-her-care/>; <https://www.the-star.co.ke/news/2019-03-25-hiv-maid-arrested-for-breastfeeding-employers-baby/>

¹⁵ See for instance <http://kenyalaw.org/caselaw/cases/view/100503>

(c) HIV in the Workplace

A range of respondents reported that HIV-related discrimination remains a problem in workplaces, with some employers requiring HIV testing and some terminating employment due to HIV status (key informant interviews 10, 28, 38, focus group discussion 4). Mandatory HIV testing in order to access medical insurance was also reported in Nairobi (key informant interview 38). A national study on human rights violations against people living with HIV commissioned by Kenya AIDS NGOs Consortium (KANCO) and the National AIDS Control Council (NACC) and carried out by KELIN in 2012, found that 34% of respondents had experienced human rights violations in the workplace (KELIN, 2015).

Even as there are no official policy barriers in relation to HIV, teachers living with HIV reported facing specific challenges, such as being overlooked for promotion and frequent transfers, complicating their sustained access to services and adherence to medication (key informant interview 33).

(i) Men who have sex with men

Criminalization of sex between men

Key informants reported that the penal code provisions affecting men who have sex with men continue to constitute a barrier to accessing quality services (key informant interview 10, key informant interview 45). Furthermore, they noted that health workers are not trained to handle key populations, and men who have sex with men fear being reported to the police if they attend health services (key informant interview 11). This does not derive from a legal obligation on health workers, rather a feeling of moral obligation that has led some health workers to call law enforcement, rather than attend to their clients. A key informant from Kitui reported men who have sex with men are not taken seriously when rape is reported, and confidentiality is not assured (key informant interview 78).

Forced anal examinations

There have been reported instances of forced anal examinations being carried out by health professionals, as directed by law enforcement bodies. Two men took this matter to the High Court, which decided, in absence of any proper guidelines by the government, that such forced testing was valid and appropriate (Kenya Human Rights Commission, 2017). In March 2018, this decision was reversed by the Court of Appeals that nullified the practice of forced anal examination on people suspected of engaging in sexual activity with a partner of the same sex (Kenya Law, 2016).

Police practices

In coastal areas, there have been reports of harassment and arrests by police officers with healthcare clinics sometimes being the target of roundups (Human Rights Watch, 2015; Okal et al., 2011). This practice has reportedly been common with police raiding organizations offering services to key populations with allegations that they are “recruiting people either to sex work or

into the gay community”.¹⁶ Human Rights Watch research carried out in 2014-15 on violence against LGBT populations in the Coast region documented multiple homophobic attacks and implicated religious leaders, police, law enforcement officers, the media and “homophobic mobs” in the attacks arrests by police officers with healthcare clinics sometimes being the target of round-ups (Human Rights Watch, 2015; Okal et al., 2011). Data from the 2014/5 national Polling Booth Survey show that 24% of men who have sex with men who were surveyed reported having been arrested or beaten up by the police or criminal elements in the previous six months (Bhattacharjee et al., 2015).

Participants in a focus group discussion in Mombasa noted that men who have sex with men who engage in sex work face constant harassment from county law enforcement officials (*askaris*), arrests and violence. They explained that, once arrested, police may not allow access to HIV or TB medication, and they voiced fears that the police might disclose HIV-related information to others (focus group discussion 2). In Kitui, informants reported that police harassment is constant, and once a person is identified as a man who has sex with men, police reportedly arrest individuals with the intention to extort them. Harassment can be so extreme as to result in men who have sex with men needing to move residences (focus group discussion 17). Also, in Kitui, key informants reported trepidation around sensitizing police on issues relating to key populations as they will then know the ‘hotpots’ and understand key populations’ vulnerability which they can use for extortion (key informant interview 76). In addition to harassment, violence has been perpetrated by law enforcement authorities against persons with differing sexual orientations and gender identities. They have been arrested, and denied assistance and protection when targeted by religious or homophobic groups (Okall et al., 2014). One key informant from Kisumu felt that the police are the biggest perpetrators of violence (key informant interview 22). This aligns with findings from a recent study that was focused on LGBTI populations (rather than just men who have sex with men), which noted: “*overall, the state’s stance toward the LGBTI community, both formal and informal, exacerbates the vulnerability of LGBTI people. Government officials and civil servants often turn a blind eye to violations of LGBTI people and even directly perpetrate acts of violence*” (Irant, 2019).

(ii) Transgender people

There are no punitive laws that specifically target the transgender community in Kenya, but there are reports from 2016 of transgender individuals being arrested for impersonation if their legal documents and appearance do not match (LINKAGES, 2016), and of discrimination against transgender people (The Kenya Human Rights Commission, 2011). Participants in a focus group discussion in Nairobi also reported similar findings noting impersonation laws can be used to target transgender people (focus group discussion 11).

The explicit recognition of only two genders in Kenya’s laws affects the lives of many transgender persons in the country, including impeding access to appropriate healthcare (The Kenya Human Rights Commission, 2011). Participants from a focus group discussion in Nairobi

¹⁶ <https://nairobi.news.nation.co.ke/news/group-officials-arrested-recruiting-youths-gay>; <https://www.pinknews.co.uk/2018/11/24/staff-arrested-lgbt-kenya-gay/>

reported that it is not within NASCOP's mandate to do transgender programming, because transgender issues are not in the KASF (focus group discussion 11). As a result, health workers often lack the capacity to address the health needs of transgender people. A report published by the Kenya Human Rights Commission in 2011 found that there were frequent reports received between May and October, 2010 of transgender people who presented to services for HIV testing or treatment being rebuked, shamed or even arrested. The same document reported instances of doctors refusing treatment or refusing to respect the privacy of patients and disclosing their status to other staff or members of the community. Such instances contribute to some transgender people staying hidden and not seeking treatment at all (The Kenya Human Rights Commission, 2011). A recent report on '*The Nexus of Gender and HIV among Transgender People in Kenya*' has documented the negative impacts on health of many of these issues as well as other harmful gender-related beliefs such as trans people being confused, mentally ill, cursed or possessed and trans people being deserving of violence (LINKAGES, 2016).

In addition to these challenges, focus group discussion participants in Nairobi also reported barriers to the use of NHIF among transgender people as a person may present as a different gender than indicated on their identification card (focus group discussion 11).

(iii) People who use drugs

Criminalization of drug use has centered the response around incarceration and punishment rather than treatment for drug dependency, rehabilitation or harm reduction, creating barriers to access to services and treatment for people who use drugs. Additionally, the discriminatory and arbitrary enforcement of the penal laws, such as the Penal Code and the Narcotic Drugs and Psychotropic Substances Control Act, have had a negative effect on uptake of health services by people who use drugs in the country (Ministry of Health, 2014a). A recent report cited a study in which 57% of people who inject drugs reported being arrested or beaten by police or askaris in the previous six months (KNCHR and ARASA, 2017). Laws are enforced in different ways depending on location with reports that in Malindi police are sensitized to harm reduction programs and supportive of their implementation (due in large parts to the sensitization efforts of civil society organizations such as the Omari project) while in Mombasa police interpret the law more strictly and show no tolerance toward people who use drugs (Kageha, 2015). In Mombasa, a key informant reported that laws and policies are the biggest challenge as there are contradictory laws indicating that people who use drugs should be taken to rehab, while there is also a 'den law' which allows police to harass drug users and make arbitrary arrests (key informant interview 9).

(iv) Women living with HIV

Studies have documented that women living with HIV in Kenya are vulnerable to property rights violations such as disinheritance of assets and personal belongings, and that these are linked to increased HIV-related vulnerabilities and difficulties accessing services and adhering to treatment (Dworkin et al., 2013). This was also reported by a key informant adding that women

are more prone to gender-based violence if they have no access to their land (key informant interview 20).

A range of punitive practices against women living with HIV have been documented in healthcare settings. For example, there have been instances where women living with HIV have been forced to take contraceptive pills in order to obtain antiretroviral therapy. In other instances, women living with HIV have been forced to undergo coerced abortion or coerced sterilization on the basis of their HIV status (African Commission on Human & Peoples' Rights, 2018; KELIN, 2014b). Five Kenyan women living with HIV have filed Petition 605 of 2014 in the High Court alleging violation of their constitutional rights due to their coerced sterilization. The petition is currently being considered by the court (KELIN, 2014e).

(v) People who engage in sex work

Research carried out with female sex workers in six counties (Nairobi, Mombasa, Kiambu, Machakos, Kisumu and Busia) in 2014 found high reported levels of human rights violations, particularly in healthcare settings and at the hands of law enforcement (NEPHAK, BHESP, KESWA and GNP+, 2015). These rights violations encompassed a wide range of issues: *“Violations around HIV diagnosis; breach of privacy and confidentiality largely resulting from unlawful disclosure of HIV status by healthcare workers; discrimination in healthcare settings and poor quality healthcare provision; lack of accessible and acceptable health services; denial of health services... exploitation and harassment including arbitrary arrests; limited access to justice in cases of rape; lack of equal protection before the law and police inaction against violations; inhumane and degrading treatment while in police custody including breach of privacy; and denial of and limited access to treatment while in police custody and prison.”*

Some of these same issues, particularly in relation to law enforcement agents, arose during key informant interviews carried out to inform this report. It was reported that some police use condoms as evidence of sex work and arrest people carrying condoms for allegedly selling sex (key informant interviews 30, 76). People who engage in sex work are also reportedly charged with crimes other than sex work, including loitering, not having identification, dress code violations, and “causing disturbance” (focus group discussion 5). Demands for sex from the police were reported by multiple sources (key informant interview 5, focus group discussions 5, 18). In Mombasa, a focus group discussion participant reported that in cases of physical or sexual violence, the police may demand sex and then not pursue the case if those filing the complaint comply (focus group discussion 5). Similarly, a key informant indicated, they are forced to bribe police weekly to avoid arrest, and they are asked for sex if police help is needed (key informant interview 5). In Kitui, similar instances of violence and extortion by the police were reported (key informant interview 76).

(vi) People in detention

As for all other citizens, prisoners' right to health is protected in the Constitution, and they are therefore entitled to access HIV services including antiretroviral therapy. There is an AIDS Coordination Unit within the National Prisons Service with well-established structures from the

prison department headquarters to all prison facilities. However, in a focus group discussion of people living with HIV, participants noted that accessing medication can be a challenge if one is arrested (Mombasa focus group discussion²). Where this occurs, it is mostly during the pre-trial period when people are held in police cells before presentation in court. The period in police custody is guided by the constitution as a maximum of 24 hours. Exceptions exist when people are arrested on Friday and arraigned in court early the following week beyond the stipulated 24 hour-period of police custody. In pre-trial holding points, there are no systems for the provision of antiretroviral therapy services and quite often clients miss their doses (key informant interview 65).

Interviews with prison officials suggested that there is access to ARVs in prison, but that chaotic intake procedures may lead to delays in fully understanding someone's health status and their need for medications (key informant interviews 31, 40). During intake, inmates are asked about their HIV status but, due to the stressful circumstances, internalized stigma or fear of stigma and discrimination, some people who require antiretroviral drugs do not disclose that at this stage, only coming forward a day or two later to provide this information. Remandees might be particularly reluctant to disclose if they are living with HIV if they are hoping for a quick release.

Upon release, ex-convicts are provided with a multi-month supply of antiretroviral drugs and prevention supplies (e.g. condoms), but no robust system exists for follow-up to ensure that these people successfully (re-)connect with HIV services (key informant interview 65)(NCAJ, 2016).

Challenges have also been noted for prisoners and incarcerated populations with physical disabilities particular as there are no facilities to cater to their needs in many correctional facilities (NCAJ, 2016).

(vii) Adolescents and young people

"Young people" is understood to encompass individuals between the ages of 10 and 24 years, with adolescents a sub-set comprising those aged 10-19. One program implementer explained that the lack of clarity about the legality of providing services to key populations under the age of 18 impeded them from providing any services to this demographic group. In general, there is confusion around 'age of consent' and 'parental consent' requirements in Kenya, as well as inconsistencies among the various laws and policies.

Children (people under 18, per the Children Act, No 8 of 2001) generally need parental consent to access contraception, HIV testing, antiretroviral therapy, pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP), safe abortion and post-abortion care, antenatal care, HIV vaccine and cervical cancer screening and treatment. However, there are exceptions to these rules in some cases (SAT, 2018). For example, a child can consent to HIV testing if they are pregnant, married, a parent or is engaged in behavior which puts them at risk of contracting

HIV, but there appears to be no legal ‘age of consent’ provision (and the law in Kenya is silent on whether consent by a parent is required) for access to antiretroviral therapy (SAT, 2018).¹⁷

With regard to access to PrEP, there are no laws, regulations or policies governing young people’s access to this preventative treatment in Kenya. However, while there is no express prohibition on the use of PrEP, guidelines on the use of ARVs developed by the Ministry of Health, National AIDS and STI Control Program (NASCO), recommend that use of PrEP be limited to research purposes. There is also no express statutory prohibition of use of PEP and national recommendations around PEP do not reference any ‘age of consent’ or ‘parental consent’ requirements (SAT, 2018). In the end, inconsistent consent requirements and lack of clear guidance around these issues can lead to medical providers requiring parental consent through an abundance of caution so as to avoid running afoul of any law.

Another barrier to services is fear that perpetrators of violence might target key population organizations providing services to key population members under the age of 18 on the pretext that they are ‘recruiting members’. This is a real problem given that these young key population members often have very little family support, do not know how to use condoms, and cannot access health services without their parents (key informant interview 76).

Similarly, a study by the Kenyan Sex Workers Association (KESWA) on adolescents (aged 14-17 years old) who sell sex found that none of the adolescents in the study wanted to be selling sex, but they had been forced into it primarily due to poverty. Very few organizations were willing to help these adolescents for fear of the potential legal implications, and the adolescents were treated as criminals rather than victims, making it very difficult for them to access the support that they need (KESWA, 2018). All exchange of sex involving children (under the age of 18) is considered exploitation and a violation of human rights (UNAIDS, 2012a); research such as the KESWA study can help understand the needs of these children and how to reach them more effectively with interventions.

The lack of activities that bring together young people living with HIV was broadly acknowledged (focus group discussions 10, 15).

(d) Stigma and Discrimination

People living with HIV in Kenya experience high levels of stigma and discrimination, impacting many aspects of life including: uptake of HIV testing and prevention services, adherence to treatment, disclosure of status, mental health, and access to socio-economic support and opportunities.

¹⁷ However, it is the responsibility of a parent of the child and Government to ensure provision of access to medical care (including ART). Note: At the time of this legal review, a bill was being discussed in parliament that seeks to establish a unified health system, including the requirement for consent i.e. the Health Bill, 2015. The Ministry of health has provided National Guidelines on Antiretroviral therapy that outlines eligibility for ARV use, regimen selection and monitoring for Treatment. The guidelines provide the criteria for when ART should be started in children however it does not clearly state whether parental consent is required or not. (SAT, 2018)

The 2014 National HIV and AIDS Stigma and Discrimination Study revealed that stigma and discrimination are very common and deeply rooted. Sixty-one percent of respondents believed HIV was a punishment for bad behavior, 48% indicated they would be scared to have their child play with an HIV-positive child at school, and 52% indicated they would not buy food in a market sold by someone known to be living with HIV (National AIDS Control Council, 2014). Despite high levels of knowledge about the causes and risks of HIV, persistent stigma and discrimination have been found to be “major barriers for testing and seeking treatment” (Harper et al., 2014).

Across a range of interviews and focus group discussions, stigma and discrimination were reported to be higher in rural areas than urban areas, and particularly in certain geographic areas, such as Central Province, the North-East region (Lamu, Mandera, Garissa, Wajir and Marsabit), as well as Turkana and other parts of the Arid and Semi-Arid Lands (ASAL) region (key informant interviews 12, 38, 43, 52).

Location-specific stigma and discrimination were widely reported. Some participants in Nairobi reported that many teachers lack information on or sensitivity around HIV and, in boarding schools, students' belongings can be subject to search which can result in public display of medications (key informant interviews 25, 27). Experiences of stigma and discrimination in health care settings were widely described, including issues around infrastructure (e.g. standalone HIV clinics, provision of yellow patient cards, visible signage indicating that services are HIV-related (focus group discussions 5, 10, key informant interviews 27, 50, 53, 81), health worker attitudes (key informant interviews 12, 13, 18, 50), disclosure of HIV test results (focus group discussions 3, 10, key informant interviews 16, 30), and attitudes of others working in the health facility (e.g. watchmen who search bags, receptionists; focus group discussion 10). HIV services at private health facilities were reported to be more acceptable, although the cost associated with them can be a barrier (focus group discussions 5, 10, 17).

A national study on human rights violations against people living with HIV commissioned by Kenya AIDS NGOs Consortium (KANCO) and the NACC and carried out by KELIN in 2012, found that 18.1% of respondents had experienced human rights violations within health care settings (third only to discrimination within the family (79%) and in workplace settings (34%)) (KELIN, 2015). People living with HIV in Kitui noted that health facilities used to have someone living with HIV working in the HIV clinic but that has been stopped, which has increased stigma and fears of unwanted disclosure of status (focus group discussion 15).

Self-stigma was also reported to be an important barrier to care-seeking for fear of discrimination, loss of social support or moral judgment (key informant interviews 1, 13, 27, 36, 56, focus group discussion 10).

As outlined below, interview and focus group discussion participants also described experiencing layered stigma due to HIV status and membership of a key population, including in

health facilities which serves as a deterrent to attending for fear of being reported to the police (key informant interview 1).

(i) Key populations

The 2014 National HIV and AIDS Stigma and Discrimination Study found that key populations, including men who have sex with men, people who use drugs and people who engage in sex work, reported experiencing two times the stigma associated with their sexual behaviors, practices and HIV status. Forty-five percent of respondents believed that men who have sex with men and people who inject drugs deserve to have HIV, and 55% believed people who engage in sex work are responsible for the spread of HIV in the community (National AIDS Control Council, 2014). As outlined below, interview and focus group discussion participants also described experiencing layered stigma due to HIV status and membership in a key population, including in health facilities, which serves as a deterrent to attending for fear of being reported to the police (key informant interview 1).

In 2012, the National Gay Lesbian Human Rights Commission (NGLHRC) was established to “promote and protect the equality and inclusion of LGBTIQ individuals and communities in Kenya, and advance their meaningful participation in society” through legal and policy reforms, strategic litigation, legal clinics, and research (NGLHRC, 2019). Initially, the application to register NGLHRC as an organization was turned down on the basis that it existed for gay and lesbian people. But in April 2015, the High Court of Kenya in Nairobi ruled the organization could register on the basis that the fundamental rights under the Constitution apply to all Kenyans, irrespective of their sexual orientation or gender identity, and that morality cannot serve as a justification to limit fundamental rights (*Eric Gitari v. Non-Governmental Organizations*, 2013). The government challenged the ruling, but in March 2019, the original ruling was upheld on the grounds that sexual minorities are entitled to the same rights as other Kenyans – a major victory by human rights campaigners (*Non-governmental Organizations co-ordination Board v. EG*, 2015), (*Non-Governmental Organizations Co-Ordination Board v EG & 5 others [2019] eKLR* (Civil Appeal No. 145 of 2015)).

A recent study found that political leaders, religious leaders and the media have all been found to be contributors toward stigma and discrimination against LGBT populations (Irant, 2019).

(ii) Men who have sex with men

Stigma and discrimination relating to sexuality and HIV are compounded for HIV-positive men who have sex with men (Micheni et al., 2015). Within communities, men who have sex with men, especially those who are effeminate, face regular stigma and discrimination, including being disowned by their families which can lead to economic hardship (focus group discussion 2, key informant interview 7). In Kitui, informants reported that men who have sex with men face the possibility of job loss, especially for those working with children, and eviction from housing (focus group discussion 17). As a result, some men who have sex with men travel far to access HIV services in the hope of not being seen attending the HIV clinics (focus group discussion 2). Many men who have sex with men from rural areas have migrated to urban areas partly to

escape the high stigma of rural areas and partly for better access to services (focus group discussion 2). A key informant in Kitui reported very high stigma toward men who have sex with men in the area noting: “The only time this community speaks in one language is around MSM” (key informant interview 81).

Stigma and discrimination also affect the quality of clinical healthcare that is accessible to men who have sex with men. Both clients and health care workers, during focus group discussions conducted between June 2013 and March 2014 in Mombasa and Kilifi, indicated that clinical environments are often biased against men who have sex with men at the provider level (Micheni et al., 2017). Participants in this baseline assessment confirmed that it was difficult for men who have sex with men to access health facilities, particularly when newly diagnosed, as they face high levels of stigma and discrimination from health workers (focus group discussions 2, 10, key informant interviews 10, 21, 53). Self-stigma alongside fear of stigma and discrimination can be a barrier to care even when actual stigma and discrimination are low (van der Elst et al., 2013).

A focus group discussion among men who have sex with men in Kitui reported challenges with drop in centers as health care workers at the facility are not well informed on key population issues. There were also a number of confidentiality-related issues reported in regard to the drop-in center. Respondents indicated that the location of the center inside of the hospital is visible to all, resulting in fear to access services. Outreach workers reportedly breach confidentiality and expose men who have sex with men. In addition, participants reported mixing of services provided for females who engage in sex work with those for men who have sex with men, resulting in breaches of confidentiality (focus group discussion 17).

In a small survey of men who have sex with men in Kisumu, 32/51 participants reported that they were not very comfortable seeking health services from a public hospital, noting that “discrimination, lack of privacy and confidentiality in healthcare facilities and discomfort with health care providers” were barriers to accessing care (Okall et al., 2014). Interview and focus group discussion participants confirmed that many men who have sex with men prefer to access private or NGO-run health facilities as staff were better trained and privacy and confidentiality were better respected, but that, particularly with the private facilities, costs could constitute a barrier (focus group discussions 2, 17, key informant interview 12). Another study in four coastal districts found that counselors reportedly failed to deliver non-judgmental services or were hesitant to talk about sexual matters, which not only stigmatized current clients, but could also intensify hesitancy around future care-seeking (Van Der Elst et al., 2015) Health workers explained that secondary stigma (stigma by health care workers toward health workers who provide health services to men who have sex with men), lack of professional education about men who have sex with men, and personal and social prejudices around serving men who have sex with men as clients all affected their approach to service provision for these clients (Van Der Elst et al., 2015).

The levels of perceived stigma and discrimination experienced by men who have sex with men differed. However, there have been repeated reports of attacks or threats to attack clinics and HIV workshops for men who have sex with men in coastal areas (e.g. in 2008, 2010 and 2012) (Human Rights Watch, 2015). In 2014, proposals were made to tighten “anti-gay” legislation,

which led to fear of attacks, a decrease in the number of men who have sex with men seeking HIV services and the temporary closure of some clinics providing HIV services to this population in coastal areas including Mombasa (Human Rights Watch, 2015).

In focus group discussions and interviews, some people reported that similar problems with stigma and discrimination arise in NGO programming where key population members are not part of the implementing team (focus group discussions 15, 17, key informant interview 76).

(iii) Transgender people

Isolation, rejection, stigma, and discrimination are high amongst the transgender population in Kenya and result in an avoidance of health services by some (LINKAGES, 2016). One study reported high levels of discrimination experienced in healthcare settings by sexual and gender minority populations, including being talked to disrespectfully and being denied services, both of which were higher among gender minority populations than sexual minorities (Müller et al., 2019). The same study also found high levels of mental health concerns among the study population.

Focus group discussion participants reported a range of barriers to accessing services including health workers asking inappropriate questions based on their presentation, gendered paperwork, and verbal and emotional violence (focus group discussion 11). Participants reported high levels of self-medication as they feared what might happen in health facilities; sometimes they go to late night pharmacies to access medications (focus group discussion 11). The lack of trans-specific services was reported to be a real problem: sometimes some trans people attend clinics for men who have sex with men or for people who engage in sex work in the hope that discrimination might be lower, but they do not feel that they belong in these spaces (focus group discussion 11).

Trans participants noted that they face high levels of stigma and discrimination in the community due to their physical appearance, with one participant remarking that “gender dysphoria is a handbag you carry with you every day everywhere you go” (focus group discussion 11).

More information is needed about the trans population, including barriers to care, lived experiences with stigma and discrimination, and how best HIV prevention and treatment services might be made available (LINKAGES, 2016).

(iv) People who inject drugs

People who inject drugs in Kenya report high levels of stigma and discrimination, including physical violence and harassment from the community, which have indirectly impacted their ability to access care (Guise, Rhodes, Ndimbii, Ayon, & Nnaji, 2016). Interview and focus group discussion participants in Mombasa reported stigma and violence from local communities who do not like there being methadone clinics there, which has had a negative impact on uptake of services (key informant interview 11, focus group discussions 1, 3).

Although many people who inject drugs report supportive caregivers, some indicate discrimination by service providers, especially the non-consensual disclosure of HIV status in cases where living with HIV is associated with addiction and death (Guise et al., 2016; Ministry of Health, 2014a). Harassment and violence by police were also reported, alongside complaints that police do not understand the health-related help that people who use drugs might need while at the police station (focus group discussion 1, key informant interview 51).

Despite barriers, a recent study commented that “more people who inject drugs reported visiting a program clinic or drop-in clinic in the past three months compared to FSWs and MSM” (Bhattacharjee et al., 2015). In Mombasa, demand for methadone programs outstrips supply, suggesting that supply side-barriers may require attention, alongside addressing stigma and discrimination relating to drug use (key informant interview 11).

Overall, very little comprehensive data is available about people who inject drugs, including their experiences of stigma and discrimination or needed services. All of this is in the context of general punitive approaches to the broad range of people who use drugs who are often, because of that drug use, more susceptible to infection, e.g. smoking pipes can increase the risks of TB, drug use can increase risk-taking behaviors for HIV and TB, and drug use can exacerbate gender inequality and violence (personal communication, UNAIDS).

(v) Women living with HIV

Research suggests that women living with HIV face increased risk for stigma and discrimination associated with HIV that negatively impacts their health, safety, health-seeking behavior and quality of care in Kenya, especially as it pertains to maternal and child health. This is often layered with discrimination associated with being female. A study in Kisumu determined that stigma and discrimination associated with HIV negatively impacted the uptake of delivery services among pregnant women living with HIV, as well as the provision of care by healthcare workers. The study found that fear of forced HIV testing and involuntary disclosure of HIV status, including to a spouse, were among the reasons women opted for a riskier home birth, rather than a skilled delivery at a health facility. Women living with HIV reported fears of involuntary disclosure of HIV status to a spouse that may result in violence, negative economic consequences such as refusing to pay for the delivery, and abandonment (Turan, Miller, Bukusi, Sande, & Cohen, 2008). Women highlighted the importance of HIV testing being voluntary, and crucially, having the choice about if and when to disclose HIV status. Some women reported that ‘assisted partner notification’ is exposing women to violence and that women feel used as a way to reach numerical testing targets and to bring men into the clinic, rather than the focus being on caring for and treating the women (key informant interview 52, focus group discussion 10). This is in line with previous research that has documented that “commonplace” non-consensual disclosure of a person’s HIV status in Kenya, alongside reports of coercion into testing, has affected community perspectives on HIV testing and on health services generally (Moyer, Igonya, Both, Cherutich, & Hardon, 2013). Research has also found extensive fear around the potential repercussions on relationships that might result from assisted partner notification (Monroe-Wise et al., 2019). Self-stigma is also prevalent among people living with

HIV, particularly among women, for fear of being gossiped about, rejected, or the target of violence (focus group discussion 10).

(vi) People who engage in sex work

Stigma, criminalization, fear of being identified, and propagation of beliefs that people who engage in sex work are 'vectors of HIV' have created barriers for people who engage in sex work to seek health services and for care providers to reach people who engage in sex work (Lukera, 2007; Micheni et al., 2015; Restar et al., 2017).

A sociodemographic and behavioral study between 2004 and 2015 that included females who engage in sex work highlighted these compounded negative social perceptions of both their HIV status and the behaviors in which they engage (Micheni et al., 2015). One underlying cause of heightened stigma and discrimination are conservative political and religious beliefs held by large portions of Kenyan society (Shangani et al., 2017).

People who engage in sex work have reported avoiding healthcare services where discriminatory questions or treatments were experienced, or where they felt they may be recognized by community members (A. G. Ferguson & Morris, 2007). Interview and focus group discussion participants noted frequent discrimination within health facilities including demands for informal payments and verbal abuse (focus group discussion 5). Where sex workers had engaged in anal sex (sometimes as a result of client violence), health workers were particularly judgmental (focus group discussion 5).

A focus group discussion among females who engage in sex work in Kitui revealed a number of discriminatory practices at health facilities. Denial of treatment at health facilities was reported by the group, noting that this is more common when violations such as rape have occurred. If a patient is believed to engage in sex work, it is difficult to have a doctor fill out a P3 form used to report assault. There were also discriminatory financial practices reported by the group. Participants indicated healthcare workers charge 1,000-2,000 Ksh to fill out the P3 form, though the police do not charge a fee. In addition, they also reported that the health facility may demand payment before treatment is provided (focus group discussion 18).

People who engage in sex work report voluntarily seeking HIV testing and services at mobile clinics that are known to be sex-worker friendly, conveniently located, and easily accessible (Human Rights Count, 2015). The Bar Hostess Empowerment and Support Program (BHESP) clinic was described as a safe place for accessing services (focus group discussion 10). However, some sex workers noted that where service providers arrive at 'hotspots' in easily recognizable vehicles they fear accessing the services for fear of being seen (focus group discussion 18).

Anticipated stigma associated with HIV was found to be a bigger deterrent in non-HIV related health care utilization for females who engage in sex work than for males who engage in sex work in Kenya. A study revealed females who engage in sex work who anticipated stigma were more than twice as likely to avoid health care services than those who did not. Females who

engage in sex work were more likely to actually experience stigma from a health care worker than male counterparts. Approximately 72% of women sex workers compared to 54% of men sex workers reported experiencing one or more manifestations of stigma in the past 12 months. Females who engage in sex work reported higher prevalence of all manifestations of stigma, including being denied health services, having HIV status disclosed without consent, and poor treatment by healthcare workers as compared to males who engaged in sex work (Nyblade et al., 2017).

(vii) Prisoners and incarcerated populations

HIV-related stigma and discrimination are reportedly high in prisons and other closed settings. In some prisons, people with HIV are given a special diet designed to help meet their nutritional needs, which can have the unintended consequence of inadvertently disclosing their status. This leads some people to try to hide their status and forego the nutritional support (focus group discussion 2).

Participants reported high self-stigma among prisoners living with HIV, especially those who seroconvert while in prison. Rates of linkage to HIV-related services upon release is poorly understood, but they are thought to be especially low among people who become infected while in prison (key informant interviews 31, 40). There is no capacity in prisons to address the mental health issues that might accompany HIV infection (key informant interview 40).

The capacity of prison staff to address HIV is limited: most prisons are under-staffed, prison officers work under very stressful conditions, and supplies and equipment are insufficient (key informant interview 51). Many prisons do not have a health facility, so staff have to escort prisoners to external health facilities which takes additional time and resources, and is sometimes simply not feasible (key informant interview 40). Levels of HIV-related stigma among staff are high, which means that few prison staff have tested for HIV or attend support group meetings (key informant interviews 31, 40).

There is no established segregation for trans-women in the Kenyan prison system. Individual cases are handled at the prison facility level by the officers in charge. No data could be found on the experiences of trans-women within the Kenyan prison system, but evidence from other countries suggests that this population might be particularly vulnerable to stigma, discrimination and violence (key informant interview 65).

(viii) Young people¹⁸

Young women reported barriers to HIV services that they face, including feeling judged by older health workers, services that do not respond to their needs in some cases, and lack of avenues for redress. All of this results in reduced uptake of services, as well as movement between

¹⁸ Due to IRB restrictions, all study participants were at least 18 years old, so these perspectives are derived from young people as of at least 18 years of age.

different health facilities, as young people seek more acceptable services (focus group discussion 10, key informant interview 65).

Focus group discussions in Kitui reported particularly high levels of stigma and discrimination against young people living with HIV and young men who have sex with men (focus group discussions 16, 17). Similar challenges in accessing services without their parental knowledge were also reported by these groups (focus group discussions 16, 17). Young men who have sex with men reportedly face the risk of expulsion from school and eviction from home if their parents find out (focus group discussion 17). A key informant from Kitui reported that young people living with HIV face the biggest challenges because their parents have told them to hide their HIV status. Some parents do not tell their children that they have the virus (key informant interview 81). The demand for young people-specific support groups, which could be a venue for empowering young people with information, and building capacity on antiretrovirals, adherence and human rights, was voiced in Kitui (focus group discussion 16).

People living with disabilities

A focus group discussion among people living with disabilities in Kisumu revealed a number of discriminatory practices in healthcare settings. HIV services are reportedly not “disability friendly”, and ARV treatment protocols are not adequately explained. Focus group discussion participants indicated healthcare workers are poorly trained to address the needs of people living with disabilities. For example, if a patient is deaf, there are reports of refusal of services if there are communication challenges with health facility staff. The group also reported that privacy and confidentiality are often not maintained for those who need assistance as doctors speak directly to the aide rather than to the patient. In some cases, if no aide is present, doctors reportedly ask anyone available to help. Stigma and discrimination particularly impact women with disabilities in regards to sexual and reproductive health. For example, there were reports that some women living with disabilities are reportedly sterilized when they give birth (focus group discussion 8).

(e) Gender Inequality and Gender-based Violence

Gender inequality, embedded within cultural norms, is shown to increase vulnerability to HIV by reducing women’s capacity to negotiate safer sex and limiting HIV prevention. Women are the main decision-maker in their own health care 39% of the time. Forty percent report that this decision is made jointly with their husband, while 21% report that their husband mainly makes this decision. Women’s participation in decision-making around their own health increases with age, education, and wealth quintile; it is also higher among women living in urban areas and women in paid employment. Among men, 51% are the main decision-makers regarding their own health care (Kenya National Bureau of Statistics, 2015a).

Gender inequality was reported by focus group discussion participants in Mombasa who noted that women often do not have autonomy or the ability to voice their opinions in their families and in the greater community (focus group discussion 3). A key informant from Mombasa reported

that men dictate the use of health facilities and control the money for services (key informant interview 3).

There are reports of women living with HIV who are blamed for their husband's or child's HIV infection on the grounds of infidelity or sex work (KELIN, 2012a). A key informant in Nairobi noted that HIV and STIs are often blamed on the woman, which can bring strife to the family (key informant interview 50).

One of the socio-cultural factors driving new infections that KASF identified was "gender inequalities including gender based violence and vulnerability of young girls" (Ministry of Health, 2014a). Key informants and participants in a focus group discussion in Mombasa reported that gender-based violence associated with a woman's positive HIV diagnosis is especially common (key informant interviews 4, 10, focus group discussion 4). Violence is reportedly worst when a woman receives a positive HIV diagnosis and her husband receives a negative diagnosis (focus group discussion 7). Key informants from Kisumu noted gender-based violence is rampant (key informant interviews 5, 15), and there are no resources at the county level to address this issue (key informant interview 15). A key informant from Nairobi reported that though the police force receives training on gender-based violence in areas where research indicates it is most rampant (Mombasa, Kwale, Kilifi, Kisumu, and Homa Bay), many officers still believe wife-beating is acceptable (key informant interview 73).

Adolescent girls from Kisumu reported a number of gender-related barriers facing young women. Rural girls reportedly face barriers reporting sexual assault as police ask for bribes. There are reportedly additional challenges if the perpetrator is a family member as victims are often financially dependent on either the perpetrator or someone else close to them within the family. In addition, male healthcare workers and landlords reportedly try to take sexual advantage of young girls lacking agency (focus group discussion 6).

In Kitui, it was suggested that the lack of programming to address violence sends the message that it is not worth reporting, which creates a gap in knowledge of the extent of the issue, alongside the gap in services (key informant interview 76).

No information could be found on the extent of violence, including rape, within prisons as it might affect vulnerability to HIV. The prison service has an internal system of reporting and addressing violence, rape and other forms of abuse within prisons, but its functionality could not be assessed.

There is a need to better understand and address gender inequalities within key and vulnerable populations. For example, comprising 10% of the drug-using population in Kenya, women face multiple forms of stigma that lead to low self-esteem, social exclusion and delay or denial of services at health facilities (Mburu et al., 2018).

A recent study based on a sample of sexual and gender minority populations suggests that, using the Demographic and Health Survey as the comparison, "the lifetime prevalence of sexual

violence among sexual and gender minority participants is more than triple than among women in the general population” (Müller et al., 2019).

(f) Underlying Poverty and Economic Inequality

Underlying poverty was cited as a barrier by a number of key informants and focus group discussion participants across regions and groups (key informant interviews 20, 10, 23, 28, 15, 75). This is particularly marked among people living in urban informal settlements and in very rural areas. Poverty rates in Kitui county were reported to be about 64% (key informant interviews 74, 78), and poverty was commonly cited as a barrier to accessing services (key informant interviews 74, 75, 78, 81). Participants in a focus group discussion in Mombasa reported that poverty is a great challenge especially for people who have HIV, TB, and hepatitis (focus group discussion 1). Specifically, the cost of health services was reported as a barrier to care (key informant interviews 9, 56, 50, focus group discussion 5). Key informants noted that services are often free, but commodities are not (key informant interviews 9, 50). One key informant noted that pharmacies do not accept NHIF, so if there are stockouts of medications at health facilities that would normally be free for clients, these additional costs may be a financial barrier. (key informant interview 53)

Informants from Nairobi, Mombasa and Kitui indicated that economic challenges result in food insecurity (key informant interviews 74, 79), particularly among young people (focus group discussion 16), and poor nutrition causing some people to default on medication (focus group discussions 2, 4, key informant interviews 4, 16, 44). One key informant noted that the 2017 drought greatly impacted treatment adherence (key informant interview 43). A focus group discussion among females who engage in sex work reported food insecurity was a challenge, noting food programs for people living with HIV no longer exist (focus group discussion 18). In addition to food insecurity, it was reported across groups and regions that transportation costs often act as a barrier to accessing care (focus group discussions 2, 4, 6, 15, 18, key informant interviews 78, 79) and can result in default on HIV treatment (key informant interview 4).

Economic inequality was also reported as a barrier by key informants and focus group discussion participants. A key informant from Kisumu reported that women are not able to actualize their rights to inheritance due to cultural issues, so if their husband dies, they are denied access to their land and face poverty (key informant interview 20). Participants in a focus group discussion reported that people living with HIV can face loss of employment due to HIV status, contributing to economic challenges (focus group discussion 4).

Inequalities in access to employment exacerbate poverty among certain population groups including, for example, women, people with disabilities, transgender people and people living in rural areas (The Equal Rights Trust, 2012).

The National Legal Aid Action Plan (2017) notes that: “The indigent remain unaware of their legal rights, lack knowledge of the court system, or simply experience unending frustrations

while seeking to access justice.” Access to justice is disproportionately difficult for people of low socioeconomic status (Office of the Attorney General and Department of Justice, 2017).

(g) Health System Factors Affecting the Availability and Accessibility of HIV Services

There are widespread health system factors that affect the availability and accessibility of HIV services. These health system factors can limit access to health services, particularly for key populations and the poor, and can exacerbate inequalities in care. Though these factors are not listed as “human rights-related barriers”, they are part of the broader right to health that the Global Fund and other donors are seeking to ensure by funding national health services. Thus, it is critical that these barriers be addressed in order to ensure access to services. Many of the key programs discussed below enable those affected by these health system factors to: (1) understand them as part of their rights to health and non-discrimination, (2) monitor them and advocate for their improvement, and (3) have legal and other forms of support to make social and legal changes that will address them.

Health system barriers to access can include stigma and discrimination, geography, uneven distribution of health care personnel, socio-economic status, lack of referral mechanisms, stock-outs, inadequate education, or poor infrastructure and information management systems (Ministry of Health, 2014a). The impact of these barriers on a person’s ability to access care can be exacerbated when combined with an HIV-positive status or engagement in criminalized behavior.

Across regions and groups, respondents indicated challenges in the availability of commodities due to stock-outs or issues with the supply chain (key informant interviews 10, 13, 17, 21). In Mombasa and Nairobi, there were a large number of reports of stock-outs for lubricant (key informant interviews 12, 17, 21, 22, 54, focus group discussion 2). Focus group discussion participants in Mombasa reported that lubricant was previously accessed from health facilities but is now only available at private pharmacies at a high cost (focus group discussion 2). Focus group discussion participants in Kitui also reported lubricant is no longer being distributed at health facilities (focus group discussion 17).

ARV shortages have also been reported (key informant interviews 10, 79, focus group discussions 10, 15, 16), as has a ‘recent’ influx of counterfeit antiretrovirals on the market (key informant interview 13). The latter was acknowledged by Dr. Jackson Kioko, Kenya’s then medical director, who was quoted by several news outlets in March 2019 stating “There is an increase of fake drugs in the market that have resulted in several cases of drug resistance to the Aids virus as a result of misuse. The fake drugs are supplied by unregistered or fake medical personnel”(Global Citizen, 2019; The Guardian, 2019). Key informants noted that where ARVs are in stock they are expiring due to poor planning (key informant interviews 18, 27). Participants in a focus group discussion noted that some patients are reportedly experiencing poor treatment outcomes due to the use of expired ARVs and are being blamed for their

rebounding viral load (focus group discussion 10). Drug shortages are especially bad in informal settlements (focus group discussion 10).

Focus group discussion participants from Kisumu reported that women are often told that they do not need to have an HIV test, and sometimes if blood is drawn for testing, tests are lost or destroyed. Respondents also indicated health care workers may not be well trained, and that there are sometimes no HIV testing kits, so patients are referred to another facility or told to come back another time (focus group discussion 7).

In addition to the challenges in availability of services, accessibility of services is also reported to be a barrier to care. There is reportedly a lack of access to health services in rural areas and lower-level public health facilities are not well equipped (key informant interview 13). Distance to health facilities is also reported to be a barrier in Mombasa, Nairobi and most significantly, Kitui (focus group discussion 5, key informant interviews 50, 80).

In Kitui, a focus group discussion among men and women living with HIV reported that HIV services are mostly available at level three-five hospitals which are fewer and further away from the community (focus group discussion 15). There were reports that due to the large size of the county and geographic distribution of major health facilities, people may have to travel up to 100KM to access HIV services (key informant interview 79). Sub-county level dispensaries reportedly lack supplies and qualified health care workers (focus group discussions 15, 16, 18). Some rural areas reportedly lack dispensaries entirely (focus group discussion 18). A lack of community infrastructure, such as poor cellular network coverage and roadway systems, were also reported as barriers in accessing services in Kitui (focus group discussion 14, key informant interviews 78, 79). One key informant explained that these issues were a particular challenge for contact-tracing (key informant interview 79).

Access to HIV- and other health-related information continues to be a problem, particularly for young people, including young key population members. Given fears about service provision for young key populations, they remain underserved with regard to information and services. For young trans people, they may also lack any information about (or even language to describe) being transgender (key informant interview 76, focus group discussion 17).

There is very little data available on the population size and health status of people who live on the streets, who, for a variety of reasons may be at elevated risk of HIV, TB and/or malaria (KELIN, 2018h). This population is generally of low socioeconomic status and may not have access to NHIF, thus limiting their access to health services.

Existing Programs to Address Human Rights-Related Barriers to HIV Services

(a) Introduction

The decentralized nature of the HIV response in Kenya means that there is a very large number of organizations implementing interventions to address HIV, many of which include some aspects of human rights-based programming to address HIV. Some of these organizations are implementing very small-scale efforts tailored to meet local needs. Others are sub-contracted by larger NGOs to implement activities under a large-scale project in a given geographic area. While this helps to ensure community involvement in interventions and locally appropriate actions, there can be an associated heavy burden of coordination. Organizations led by key populations and/or working at the grassroots often struggle to access funding, with many funders preferring to fund larger implementing organizations (focus group discussion 17, key informant interviews 38, 76). While this may simplify coordination somewhat, it also risks programs being implemented that are not appropriately tailored to local communities by staff who do not reflect the constituencies they serve, e.g. it can be argued that trans populations are best situated to lead interventions designed to address HIV-related human rights issues among transgender communities as they have lived experience of the issues at hand.

Many of the programs described below encompass elements of more than one of the program areas recognized to reduce human rights-related barriers to HIV services. They have been included in the program area that seems to best encapsulate the overarching aim of the program. Furthermore, some programs include attention to HIV and TB; those programs have been included here and are not repeated in the TB section.

(b) Stigma and Discrimination Reduction

A wide range of government agencies, NGOs and CSOs work to reduce HIV-related stigma and discrimination.

(i) Peer/psychosocial support programs

A number of CBOs have facilitated the creation of support groups for people living with HIV around the country. Usually organized by population, key population-specific support groups are often attached to drop-in-centers (DICES). There are specific groups for men who have sex with men, female sex workers, people who inject drugs, adolescent girls and young women, adolescents and young people, and transgender populations. While challenges with sustainability have been noted, particularly in rural areas, the value of support groups in helping people cope with stigma, including self-stigma, has been widely recognized (focus group discussion 7, key informant interview 53), (NEPHAK, 2018b), (Trust, 2018a). Psychosocial support group meetings have even been created for people living with HIV in prisons, and these for a have been used to encourage meaningful engagement of inmates living with HIV (HealthStrat, 2015).

Successful examples of psychosocial support group training exist, such as work by NEPHAK and EGPAF with young people that included information about stigma and discrimination reduction, implemented in 2017-2018 in Nairobi, Turkana, Siaya, Kisumu, Busia, Kakamega, Migori, Kisii and Homa Bay. The Sauti Sikka network, while requiring some capacity building, is well situated to carry out such work with adolescents and young people.

(ii) Community education

A variety of modalities has been employed for community education on stigma and discrimination reduction ranging from sensitization of media representatives to sensitization meetings with a range of community leaders including religious leaders, chiefs, community leaders, health workers and police. Most of this work has been on a small scale and efforts have not been coordinated. Some workshops have targeted specific constituencies, such as religious leaders across all faiths, teachers or adolescents. Some informants highlighted the value of using dialogue meetings as an entry point to set a tone of collaboration before offering more formal training (key informant interviews 13, 17, 76). Where knowledge of HIV (and TB) is low, even providing general information on these diseases to the community might help counter stigma (focus group discussion 15).

Substantial efforts have been made to address stigma and discrimination in the workplace, such as through training trade union branch officials, establishing an informal economy steering committee on HIV to advise associations within the informal economy, and working with the Federation of Kenyan employers and others to build capacity of human resources managers in different companies on appropriate legal frameworks relating to HIV (key informant interview 28), (ILO, 2014). NEPHAK and Afya Pwani carried out work with the Kenya Network of Positive Teachers in 2017-2018 to help address stigma and discrimination in schools in Mombasa.

LVCT Health has trained 2,700 health workers across 15 counties on basic sign language and developed over 50,000 disability-friendly information products on HIV and sexual and reproductive health. In their service provision they have staff trained in Kenyan Sign Language and Braille and typing services available for the visually impaired. Although this work is not explicitly rights-based, this is a good example of promoting non-discrimination by ensuring that services and interventions work for different populations.

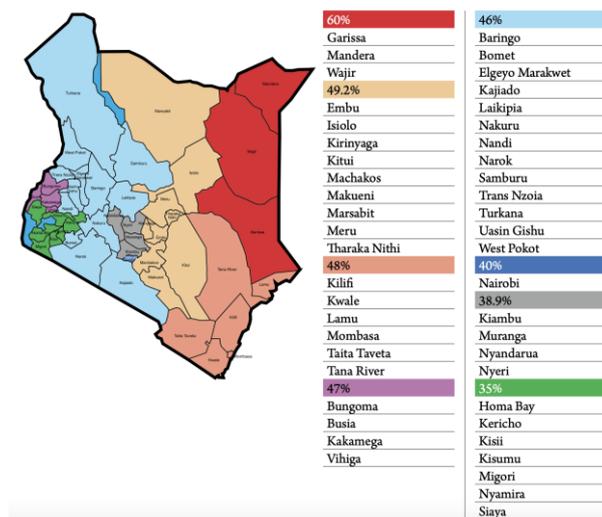
The work of PEMA Kenya to bring together religious leaders and LGBTI communities following the attacks on men who have sex with men in Mtwapa in 2010 is seen as very successful. Using a peer-to-peer model, they have run several workshops. Their training manual (the content of which was not analyzed for the purposes of this report) has been widely disseminated and they have trained over 500 religious leaders to date (Iranti, 2019).

With funding from USAID, 'Gender and Sexuality Diversity' training has been carried out with some of their implementing partners, aiming to sensitize community leaders with a view to developing a joint plan to promote gender diversity and inclusion (Health Policy Project, 2015). This work could be a useful foundation on which to build, particularly if strong evaluation can be incorporated to document the effectiveness of these trainings.

(iii) Stigma research, measurement and analysis

A national HIV and AIDS Stigma and Discrimination study was carried out in 2014, and found high levels of HIV-related stigma and discrimination, particularly very high levels of concern among people living with HIV about disclosing their status and a very high proportion of people living with HIV reporting experiencing the negative impacts of stigma on themselves, their family and the community (National AIDS Control Council, 2014). The report also documented the double stigma experienced by key populations due to both HIV and their sexual behaviors and practices. Notably, low levels of stigma were found across two domains: people fearful of contracting HIV through non-invasive contact with people living with HIV, and people living with HIV who think they have experienced HIV-related stigma in the last year. The lowest levels of stigma were found in some of the most HIV-affected counties, including Homa Bay, Kisumu and Migori, while the highest levels of stigma were found in the north-east in Garissa, Wajir and Mandera (see figure below). These patterns are reflected in the indicators around attitudes toward people living with HIV in the 2014 DHS report. In addition, the DHS report found less acceptance in rural areas than urban areas as well as an association between lower educational attainment and less acceptance of people living with HIV (Kenya National Bureau of Statistics, 2015a).

Figure 1: County HIV Stigma Index



Source: (Kenya National Bureau of Statistics, 2015a)

In 2017, KESWA carried out important research to investigate and document the impact of the legal environment on sex work-related violence as well as challenges presented by the legal environment on mechanisms to address violence against sexually exploited adolescents who sell sex. Both studies were carried out in Nairobi, Mombasa, Kisumu, Busia and Nakuru (KESWA, 2018).

A polling booth survey incorporating females who engage in sex work, men who have sex with men, people who inject drugs and transgender people was carried out across 34 counties in early 2019, but the report could not be located.

While it seems likely that program implementers would use these data to inform their work, none of the stakeholders interviewed spoke about using these data in this way. However, the data were explicitly used to inform the national proposal to the Global Fund for the current HIV and TB grant.

(c) Training for Health Care Workers on Human Rights and Medical Ethics Related to HIV

Many different CBOs and NGOs are providing sensitization and training to health care workers that would appear to cover human rights and medical ethics related to HIV. The diversity in content, depth and duration is striking. Some trainings have focused on specific key populations while others have been centered around providing stigma-free services, screening for gender-based violence among key populations, or providing more effective referrals between health facilities. Some more in-depth trainings have covered provisions of the Constitution and how they relate to the human rights of key populations, actions that might constitute human rights violations and health workers' duty to report such violations, as well as how to access the reporting system for such activities. These trainings are funded by different donors and implemented by different organizations, with nobody taking responsibility for the overall coordination of this work. As just one example, with funding from UNDP, KELIN trained 209 health workers on human rights between July 2012 and June 2017 in the counties of Nairobi, Kisumu, Homa Bay, Kakamega, Bungoma, Mombasa, and Kilifi.

While these efforts have been widely welcomed, key informants voiced concern about their *ad hoc* nature as well as the lack of continuous engagement (focus group discussion 11, key informant interview 46); these efforts are dependent on external funding, which raises important questions about their sustainability. The need for continuous engagement stems from the importance of repeat exposure to these trainings, as well as the challenges posed by high turnover of health workers (key informant interview 46). A part of the problem rests in the fact that Kenya has a very large gap in data on stigma and discrimination in health care settings. Thus, interventions are not necessarily being targeted to the health facilities most in need of them (personal communication, UNAIDS).

Some key informants reported that money originally budgeted for health care worker training was re-allocated to training of police, with one interview participant suggesting that training police was seen to be easier or more effective than training health care workers (key informant interview 32). The reasons underlying this are unclear but warrant investigation given the continued discrimination experienced within the healthcare setting. One key informant suggested that the sensitization of health care workers and police has not worked due to the rotation policies whereby these duty bearers regularly move to new stations (key informant interview 76).

In Kitui county, more than in the other three (more urban) counties where data collection took place, community health volunteers were used to support the provision of HIV services. People living with HIV highlighted the need to train more community health volunteers as they have a positive impact within the community and are ideally situated to provide information about HIV as well as to provide support services (focus group discussion 15, key informant interview 74). There was concern, however, that, with turnover of NGOs implementing donor-funded work, recently trained community health volunteers have been laid off, leaving a gap in support (focus group discussion 15).

Furthermore, county-level legal frameworks are variable with regard to community health volunteers. In Kitui, one organization noted that there is no legal framework for the entire community health system, and no funding to support this line of work (key informant interview 80). These structures are needed along with a budgeted plan for absorption of community health volunteers into the county health budget.

While most community health volunteers currently provide information relating to the more biomedical aspects of HIV prevention and treatment, where wide networks exist this might be a useful entry point for introducing information on human rights and patients' rights to community members. Some organizations, such as the Bar Hostess Empowerment and Support Program (BHESP), are already carrying out training for community health volunteers that includes explicit attention to human rights.

(d) Sensitization of Law-makers and Law Enforcement Agents

Similar to the training of health care workers described above, there is a plethora of different organizations involved in sensitizing lawmakers and, particularly, law enforcement agents on HIV and human rights. Although NACC and NASCOP published a training of trainers manual for sensitizing police on their role in a rights-based approach to HIV prevention among key populations in 2016, it is not being systematically implemented and the content, duration and frequency of current training efforts vary widely (NACC, 2016)¹⁹. There is currently some

¹⁹ A quality review of this manual could not be carried out as the NACC and NASCOP websites have not been functional during this period of the research.

support for one-off adoption of this manual by the police academy and training of a pool of trainers, but more sustained support will be important (key informant interview 11).

Current pre-service training for police includes a module on “Human rights, police ethics and accountability” as well as training on stigma and discrimination, but neither is specific to HIV and TB. In-service training is provided to officers on gender-based violence in counties where research has shown this to be particularly prevalent (including Mombasa, Kwale, Kilifi, Homa Bay and Kisumu) (key informant interview 73). While this is welcome, it is acknowledged that it is insufficient in both scope and scale.

Where trust can be cultivated, sensitization of law enforcement officers is seen as an important adjunct to service provision at ‘hotspots’ or through drop-in-centers to ensure that law enforcement officers can collaborate with and support these efforts (Amakobe, Nzola, & Mwangi, 2016).

Some of these trainings have also included Members of County Assembly (elected members of the county government who are critical to policy-making and priority-setting at county level), but this has not been systematic. Furthermore, there appears to have been little sensitization of national-level lawmakers.

The training of judges, magistrates and, more recently, prosecutors that has been carried out appears to have been particularly successful, with reports of trickle-down training of other judges (key informant interview 42). Inclusion of key population representatives to humanize them and the issues they face appears to be an important component of these trainings.

On a smaller scale, there has been some training of prison officers on HIV and human rights (key informant interviews 3, 35).

(e) Legal Literacy (“Know Your Rights”)

Peer educators play a broad role in human rights mobilization and legal literacy, as well as reduction of stigma and discrimination and facilitating linkage to and retention in HIV care. In 2014, NASCOP issued national guidelines for HIV/STI programming with key populations, which included recommendations for peer educator ratios of 1:80, 1:40 and 1:40 for females who engage in sex work, men who have sex with men and people who inject drugs, respectively (NASCOP, 2014). The exact role of the peer educators as well as their remuneration appears to vary, but peer educators appear to be an effective way of reaching large numbers of people living with HIV and other key populations with useful information about HIV, human rights and relevant laws. As such, ensuring that they can operate within supportive structures is key not only for stigma and discrimination reduction efforts but also for supporting the other functions that peer educators fulfil. NASCOP has published guidelines for training peer educators for programs with female sex workers (NASCOP, 2017). For young people, peer education for both in-school and out-of-school youth are in operation (NEPHAK, 2018a; WOFAK, n.d.-a). Some

peer education interventions are small scale, such as HAPA-Kenya's work in Mombasa, with 22 peer educators trained between January and March 2019 or NEPHAK and the Kenya Red Cross Society's training of 10 female sex workers as peer educators in Kakamega and West Pokot. Other programs are larger scale such as the LINKAGES program through which DPHK implemented peer education of men who have sex with men as well as female and male sex workers (as part of a much larger package of interventions) in 15 counties (Bungoma, Busia, Kakamega, Kiambu, Kilifi, Kisumu, Kwale, Machakos, Mombasa, Nairobi, Nakuru, Narok, Taita Taveta, Turkana) between 2015 and 2020. Under the current Global Fund grant, DPHK is also training peer educators among the general population and key populations in 34 counties (Bungoma, Bungoma, Busia, Elgeyo Marakwet, Garissa, Homabay, Kajiado, Kakamega, Kilifi, Kisii, Kisumu, Kwale, Laikipia, Lamu, Machakos, Manderu, Marsabit, Migori, Mombasa, Murang'a, Nairobi, Nakuru, Narok, Nyamira, Samburu, Siaya, Taita Taveta, Tana River, Trans Nzoia, Turkana, Uasin Gishu, Vihiga, Wajir, West Pokot). In 2017, LVCT reached over 18,000 fisherfolk in Migori and Kisumu counties through peer education. Although there is no evidence to suggest that these large-scale peer education efforts include human rights or legal literacy, they could provide a network of peer educators who, when they undergo refresher training, could be trained on human rights.

Under their current Global Fund grant (2018-2021), the Red Cross is carrying out 'Know your rights' campaigns through organizations of adolescents and young people (in Kisii, Siaya, Machakos, Turkana and Kilifi) and networks of people living with HIV and key population organizations (in Manderu, Garissa, Wajir, Kitui, West Pokot, Tana River, Kiambu, Samburu, Elgeyo Marakwet, Turkana, Kwale and Taita Taveta). The current state of implementation is not entirely clear but some work has been carried out on training manuals. The plan is that these campaign activities including distributing IEC materials and training peer educators be integrated into other ongoing activities. The campaigns are also to be linked to legal aid clinics to help provide mechanisms through which people can claim their rights.

KELIN, NEPHAK and the Law Society of Kenya, through their 'Enhanced Protection of People Living with HIV's rights through participatory governance' project, carried out legal literacy work with people living with HIV, healthcare workers, community leaders and county leaders in Kisumu, Homa Bay, Kakamega, Bungoma, Mombasa and Kilifi. This resulted in reported demystification of the law as it relates to people living with HIV and their rights, active engagement in promoting the rights of people living with HIV and cross-sectoral networking.

Small-scale legal literacy efforts have been carried out across the country and with different populations including people living with HIV, sex workers, men who have sex with men, people who use drugs, women, young people and prisoners. Some organizations have also carried out sensitization of community and religious leaders on how the law and human rights relate to HIV. Sometimes these legal literacy efforts also encompass attention to TB alongside HIV.

Key informants reported that very limited funding is available for legal literacy work so implementers often 'attach' this work to other activities such as events or other training e.g. on violence prevention (key informant interviews 36, 38).

In key informant interviews and focus group discussions, participants spoke about legal literacy work that involved sensitization and training rather than any large-scale media campaigns to address this issue.

(f) HIV-related Legal Services

(i) Paralegal training

There has been a lot of paralegal training in the last few years with little standardization across different implementers. This seems to cover most of the country and cut across key and vulnerable populations.

The Kenya School of Law runs a two-year “Diploma of Law (Paralegal) Studies program” that seeks to “serve among others the Kenya Police, Kenya Prisons, the Judiciary, the State Law Office, the Bar and Government departments”. Paralegals that work as grassroots legal advocates, however, typically do not have this kind of formalized paralegal training. A number of non-governmental organizations train community paralegals on different areas of legal aid. For example, Kituo cha Sheria, working with UNHCR Kenya and the International Rescue Committee, offers training on empowering community representatives on access to justice issues. Kituo cha Sheria’s initial training lasts for two weeks and refresher courses are conducted quarterly. The Legal Resources Foundation Trust conducts one-year-long trainings. The Paralegal Support Network created a manual and curriculum to “harmonise and standardise paralegal training and coordination”, and the Legal Resources Forum Trust has sought to regulate and train paralegals, but none of this work is specific to HIV or TB.

It is very difficult to quantify how many paralegals have been trained or are actively working in Kenya. All of the following organizations have trained paralegals (although not all HIV/TB-specific): International Commission of Jurists–Kenya Chapter (ICJ), Kituo Cha Sheria, International Federation of Women Lawyers–Kenya Chapter (FIDA), Legal Resources Foundation Trust (LRF), Muslims for Human Rights (MUHURI), Namati, Plan International, Kenya Land Alliance, Ogiek People’s Development Program, and Kivulini Trust, BHESP, KELIN, Nubian Rights Forum, Haki Centre, and Wajir Human Rights Network. Some paralegals have come together to create ‘response teams’ to assist their community in the face of police violence or other rights violations (key informant interview 36). Even where paralegals are not working specifically on HIV and TB, they may still be useful resources as their overarching mission is to improve access to justice for vulnerable populations.

The Kenya Red Cross Society, through its current Global Fund grant, has conducted three-week paralegal trainings and have engaged 310 paralegals to date – 150 from key populations and 160 people living with HIV. The key population’s paralegals are located in Kisumu, Nairobi, Mombasa, Kwale, Kilifi, Nakuru and Kisii. The geographic coverage of this work with people

living with HIV is: Mandera, Garissa, Wajir, Kitui, West Pokot, Tana River, Kiambu, Samburu, Elgeyo Marakwet, Turkana, Kwale and Taita Taveta. The idea is that paralegals be linked to pro bono lawyers and senior paralegals for mentorship and support as well as to the court users' committees. At the county level, paralegals form informal networks in order to join the paralegal support network (PASUNE), that will help facilitate coordinated support and mentorship.

A recent study identified some key success factors across a range of paralegal training efforts in Kenya, including: the quality of paralegals' relationships with principal institutional actors and local leaders, having legitimacy through some form of accreditation and clarity around their role, and a supportive 'parent civil society organization' that provides a combination of training, referral contacts, ongoing logistical support/guidance, and monetary support (Moy, 2018).

Paralegal services seem to be particularly well-embedded in gender-based violence resource centers in some hospitals as well as in some drop-in-centers (key informant interviews 15, 26).

(ii) Pro bono lawyers

There is a strong demand for *pro bono* lawyers to work on HIV-related cases, but the supply is limited. Perhaps the strongest network is that of KELIN who have approximately 100 *pro bono* lawyers who are willing to work on HIV- and TB-related cases, including in some of the surrounding counties (key informant interview 38). An online database of such attorneys has also been developed to gain access to the participating attorneys. These attorneys receive specialized sensitivity training. From 2012-2017, this program has given direct legal advice to 127 clients, while 253 cases have been referred for alternative dispute resolution. The lawyers were trained from various counties including Embu, Homa Bay, Kisii, Kilifi, Kisumu, Marsabit, Meru, Mombasa, Nairobi, Nakuru, Nyeri, Siaya, Trans Nzoia and Uasin Gishu (KELIN, 2018f).

Other organizations have also recently trained paralegals and/or lawyers on issues relating to HIV or TB, with some paralegals already linking clients to *pro bono* lawyers and others hoping that training participants might agree to take on *pro bono* cases in the future (key informant interviews 38, 81).

(iii) Court Users Committees

Court User Committees bring together a range of stakeholders from the justice sector (including court users) with a view to enhancing public participation and stakeholder engagement, and helping to build public understanding of court operations and promote an effective approach to the administration of justice (NCAJ, 2019a, 2019b).

(iv) Legal advice hotline for sex workers

A telephone hotline that operates 24/7 and is run by female sex worker peer educators provides advice, including legal advice on sexual assault and economic violence, as well as condom deliveries (key informant interview 26).

(v) Strategic litigation

Although seen by many as a last resort, some civil society organizations have used strategic litigation as a strategy to challenge laws that are perceived to be barriers to accessing HIV, TB or other health services. Legal services are provided keeping in the mind the jurisprudential value of law which can affect the fundamental and human rights of individuals (KELIN, 2019b). Recent HIV-related cases include the case of the coerced sterilization of women living with HIV and the ongoing challenge to Section 26 of the Sexual Offences Act that criminalizes HIV transmission (key informant interview 38).

(vi) HIV/AIDS Tribunal

The HIV/AIDS Tribunal is seen as an important avenue for access to justice in relation to HIV, with the court reportedly handling about 45-50 cases per year (key informant interview 47). However, awareness of the Tribunal remains low, and delays in handling cases have been reported as have challenges of accessibility for people outside Nairobi (key informant interviews 28, 47), (BHESP, 2018). The Tribunal is located in Nairobi and people must be physically present at the tribunal in order to bring a complaint. This creates a huge barrier for most people in Kenya who may not be able to afford to travel to Nairobi and stay there for the duration of a trial. Devolution occurred after the Tribunal was instituted but, in order to ensure its accessibility, county level points of access are needed.

There has been some recent work to increase awareness of the Tribunal e.g. by sensitizing employers and workers, as well as capacity-building of the Tribunal which has been welcome but remains very centralized (key informant interview 28). The HIV/AIDS Tribunal has carried out sensitization in 20 counties to date covering the laws in place that protect people living with HIV, key and vulnerable populations and the general population, stigma and discrimination, and the HIV/AIDS Tribunal itself.²⁰

(g) Monitoring and Reforming Laws, Regulations and Policies Relating to HIV

Local and international NGOs alike are involved in monitoring and seeking to reform laws, regulations and policies relating to HIV. In some cases, this involves building the capacity of key population members or community-based organizations with a view to expanding the network of individuals and organizations who can participate in this work, while in other cases, organizations seek to directly influence laws, regulations and policies through a range of different strategies. These might include participation in national or local level technical working groups, community dialogues with local or national level government officials, targeted advocacy with decision-makers at different levels or simplifying legal or policy documents to

²⁰ Personal communication.

make them more accessible to communities and training them as advocates (key informant interviews 13, 14, 30, 48).

At the national level, civil society is well-organized and able to engage in national-level policy-making through existing structures such as technical working groups. However, there are still challenges, particularly at the county-level with ensuring community engagement in policy-making processes, prioritization exercises or technical working groups that monitor implementation (focus group discussion¹⁵).

One organization has trained members of the media in six counties (Kakamega, Kisumu, Migori, Siaya, Homa Bay and Mombasa) on how to monitor implementation of the right to health in the Constitution so that the media might be an additional channel of accountability (key informant interview 38).

A group of five people living with HIV and the Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN) are currently challenging the constitutionality of Section 26 of the Sexual Offences Act before the High Court for discriminating against people living with HIV, women and people living in poverty. The petitioners have started a campaign called Positive Justice to raise awareness of the negative effect of laws which impede the rights of people living with HIV. They are also engaged in advocacy to raise awareness among stakeholders, lawmakers, media, the judiciary and the MOH (KELIN, 2018c).

In 2016, KELIN developed a training manual for the benefit of CSOs and other organizations to carry out monitoring activities centered around the right to health within the Kenyan Constitution (KELIN, 2016b). Based on this module, a training for community health advocates was carried out in 2017. Thirty community health advocates from Nairobi, Mombasa, Kisumu, Homa Bay and Migori counties were trained in HIV, TB and general human rights knowledge on monitoring human rights abuses, laws and policies (KELIN, 2017). They hold regular feedback meetings and conduct community outreach by leveraging existing community platforms such as chief's *barazas* (councils), community dialogue forums, social gatherings, seminars/workshops, trainings and in health facilities.

The current Global Fund grant includes an allocation for engaging key population-led and community-based organizations to screen and report human rights violations, aiming to engage two additional organizations in each of the ten countries where it operates.

A few organizations are also involved in global-level advocacy processes, such as shadow reporting to treaty monitoring bodies, the Commission on the Status of Women and the African Union (key informant interview 30). The LGBT community has been particularly active in raising concerns under the Universal Periodic Review mechanism, which has led to repeated recommendations from the Human Rights Committee that Kenya decriminalize sexual relations between consenting adults of the same sex and put an end to the social stigmatization of homosexuality (Irantí, 2019).

At the national level, there was coordinated advocacy surrounding the High Court case on the decriminalization of sexual relations between consenting adults of the same sex. Although this legal challenge was not successful (see above), commitment remains to appeal the ruling and maintain pressure around this issue.

(h) Reducing Discrimination Against Women in the Context of HIV

PEPFAR's DREAMS program provides individualized, evidence-based, and comprehensive HIV care and gender-based violence (GBV) prevention, treatment, and protection services for adolescent girls and young women (USAID, 2019). Working through a number of implementing partners, the project has had an important impact on adolescent girls and young women, including through economic empowerment, provision of information on safer sexual practices and provision of appropriate health education that enables them to make informed decisions about their reproductive health. The work is focused in seven counties: Homa Bay, Kisumu, Siaya, Nairobi, Migori, Mombasa and Kiambu. It reportedly reached almost 145,000 adolescent girls and young women in 2016-17 (DREAMS, 2016). Project beneficiaries spoke highly of the intervention, suggesting that it is truly transforming lives (focus group discussion 10).

With a multitude of implementers, DREAMS has a slightly different emphasis depending on who is carrying out the work. KELIN, under DREAMS, focused on facilitating access to sexual and reproductive health justice among orphans and vulnerable adolescent girls in Kisumu and Homa Bay counties (2017-19). While the work cuts across many of the human rights program areas, it is included here due to its focus on adolescent girls and young women. Although overall results were slightly mixed, significant improvements were found between baseline and endline in a range of gender-based violence indicators, knowledge of avenues for accessing justice and attitudes and behaviors relating to condom use among adolescent girls and young women (KELIN, 2019a). Other implementers appear to have focused less on human rights and more on the gender-related aspects of the package, such as gender-based violence.

LVCT has provided a range of gender-based violence services, including, in 2016 – 2017, supporting 66 public health facilities to provide gender-based violence services, sensitization of health workers and police on handling cases of gender-based violence and reaching over 30,000 community members with information on gender norms. Although not explicitly rights-based, this might constitute an entry point for creating integrated services (LVCT Health, 2017).

In 2017 – 2018, NEPHAK and Afya Pwani held 19 community education sessions in Mombasa to address gender norms and practices that fuel HIV. Other interventions targeting women in the context of HIV that could be an entry point for rights-related work include DPHK's ongoing work to improve economic livelihoods and social protection among adolescent girls and young women in Embu, Kajiado, Kitui, Machakos, Makeni, Meru, Mombasa, Nairobi, Nakuru, Nyeri, Tharaka Nithi, Uasin Gishu, and the Gender Violence Recovery Centre's extensive portfolio of

work addressing different aspects of gender-based violence (including some human rights issues).

There has been some violence prevention and response and human rights training for sex workers carried out by NASCOP and partners. Training locations are selected based upon reported crises at hotspots, and topics covered include communication skills, behavior, where to report, and violence prevention and response (key informant interview 26). The training of peer educators carried out by HIV and AIDS People Alliance of Kenya (HAPA-Kenya) in Mombasa also covered reporting incidences of violence (HAPA, 2019).

OSIEA has funded some work to address the rights of women from different key and vulnerable populations including women in prisons and women who use drugs. Carried out between 2016 and 2018, these projects have reached over 750 women with information on gender, rights and women's empowerment.

Women Fighting AIDS in Kenya (WOFAK) has carried out work in Lamu, Migori and Isiolo on implementation of the WHO guidelines on the sexual and reproductive health and rights of women living with HIV. They plan to expand this to another three counties (key informant interview 42). Meanwhile, COFAS, Afya Alisi and World Vision sensitized over 20,000 youth, young women and boda boda riders on sexual and reproductive health and rights.

Alternative dispute resolution has been used for issues in relation to land and inheritance rights for a relatively long time. Various organizations are continuing with work and reporting successful outcomes in relation to stigma, disinheritance and ensuring that women get access to land tenure (key informant interviews 20, 56). More recently, the Bar Hostess Empowerment and Support Program (BHESP) has started using alternative dispute resolution for cases of gender-based violence. This began because of the very low number of reported cases of gender-based violence that go to court, and even lower number that reach resolution through the courts. To date, they have handled a range of cases including sexual violence, stigma and discrimination (carried out by health workers and police), verbal abuse, economic violence and sexual harassment of sex workers by police. They currently handle approximately seven cases per month. This mechanism is reported to be widely acceptable due to its economic accessibility and rapid resolution of cases (usually within one week) (key informant interview 26).

7. Baseline Findings – TB

This section of the report focuses on findings relevant to TB including the epidemiological context, political and legal environment, barriers to accessing services, and existing programs in place to address human rights-related barriers to TB accessing services.

TB epidemiology

(a) General

There were 85,188 cases of TB notified in Kenya in 2017, with incidence much higher among men than women (WHO, 2018). Between July 2015 and July 2016, the government of Kenya conducted a nationwide, cluster-based, cross-sectional TB prevalence survey among adults aged 15 and older. This was the first assessment of adult TB prevalence conducted since 1958, and findings suggest a more severe disease burden than that estimated by the WHO. Results of the assessment suggest a bacteriologically confirmed pulmonary TB prevalence rate of 558 per 100,000 adults in 2016. Prevalence among males was more than double that of females at 809 per 100,000 adult population and 359 per 100,000 adult population, respectively. Among men, prevalence is highest in the 25-34 age-group, while among women, prevalence is highest in the over 65 age-group (Enos et al., 2018; Ministry of Health, 2016). TB prevalence is higher in urban areas than rural areas (Enos et al., 2018).

(b) Key and Vulnerable Populations

Limited data are available regarding TB among key and vulnerable populations in Kenya. WHO estimates that about 28% of TB cases and 18,000 TB-related deaths occurred among people living with HIV in Kenya in 2017 (WHO, 2017a). Overall, the risk of TB infection is 16- 27 times greater in people living with HIV than in the general population. With a national rate of HIV/TB co-infection of 30%, the four counties with the highest rates of HIV/TB co-infection are Homa Bay (64%), Siaya (63%), Kisumu (59%) and Migori (52%) (National AIDS Control Council, 2016).

The 2011 IBBS did not collect data on TB prevalence among people who use drugs. A 2013 study of two district hospitals in Kenya found TB prevalence rates of 5.5% and 2.4% among health workers (Kanyina, Boru, Mucheru, Amwayi, & Galgalo, 2017). It has been reported that TB case notification rates in Meru and Embu prisons were 4-10 higher than in the surrounding populations in 2012 (Ministry of Health, 2014c).

Of the 85,188 TB cases notified in 2017 in Kenya, about 10% were pediatric cases. 5% of all notified cases occurred in children 0-4 years of age, 2% in children 5-9 years of age and 3% among children aged 10 to 14 years. Of the pediatric cases notified, 94% were tested for HIV, and there was a 19% coinfection rate. Treatment outcomes for cases notified in 2016 indicated a 4% death rate among all pediatric cases and a 9% death rate among previously treated pediatric cases (Ministry of Health, 2017b).

A study in western Kenya found that 60% of health workers had latent TB with risk proportional to time exposure, highlighting the vulnerability of this group particularly where health workers work long hours (Agaya et al., 2015).

Overcrowding, a known risk factor for TB transmission, is widespread in Kenyan prisons. Data on TB prevalence in prisons is limited, but TB was reported to be one of the three most pressing health issues in a sample of prisons audited in 2015 (NCAJ, 2016). One study in Kamiti Prison found TB prevalence to be seven times that of the general population (Aywak, Irimu, Mayo, Okaru, & Bhatt, 2005). Another study in Nakuru Prison found that HIV was a strong risk factor for TB, with estimated risk of clinical TB in prisoners living with HIV between 6-26 times that of prisoners not living with HIV (Anyangu, Kikuvi, & Muchiri, 2010).

By similar logic, and based on data from other places, there are often high rates of TB in urban informal settlements. No data was found on TB within urban informal settlements.

Refugees are also at increased risk for TB, including multi-drug resistant TB even as data on this population in Kenya is very limited. In January 2019, there were 475,412 registered refugees and asylum-seekers in Kenya (UNHCR, 2019). Recent data show that refugee patients comprise 18-20% of patients on treatment with drug-resistant TB in Kenya (National Tuberculosis Leprosy and Lung Disease Program, 2016). A recent study on treatment outcomes among people with MDR-TB in Dadaab refugee camp found that MDR-TB prevalence was higher among men than women, that it primarily affected people aged 15-54, and that most people had previously been treated for TB. The study found a treatment success rate of over 90% (Onyuka, 2017). Undocumented refugees within the camps face additional barriers accessing basic services such as food and health services (Medecins Sans Frontieres, 2019).

Global commitments Kenya has made a commitment to the key programs for TB as expressed in the 2018 *Political Declaration of the High-Level Meeting of the General Assembly on the Fight Against Tuberculosis* (United Nations General Assembly, 2018).

Protective Laws and Policies Relevant to Access TB services

(a) National Strategy

The national TB response in Kenya is led by the National Tuberculosis, Leprosy and Lung Disease Program (NTLD Program) which developed the National Strategic Plan for Tuberculosis, Leprosy and Lung Health 2019-2023. The NTLD program is connected to the county level via county and sub-county TB and leprosy coordinators who provide implementation support. For the first time, the National Strategic Plan for Tuberculosis, Leprosy and Lung Health 2019-2023 calls for county level strategic plans and county integrated development plans to address local needs and help mobilize local resources to achieve national

goals. Human rights and gender are highlighted in the National Strategic Plan for Tuberculosis, Leprosy and Lung Health 2019-2023, which identifies the implementation of programs to reduce stigma and discrimination, legal literacy campaigns, legal services for those who have experienced human rights violations, and the integration of TB services into the reproductive maternal and child health services to expand access for women and girls as strategic interventions to remove legal, gender, and human rights barriers to TB services (Ministry of Health, 2019). The National Strategic Plan identifies a number of key populations including those who live in urban slums, healthcare workers, prisoners, people living with HIV, people living with cancer or diabetes, people who inject drugs, the elderly, refugees and mobile populations, men 25-34, and the homeless (Ministry of Health, 2019).

(b) Policies

In response to the 2016 ruling on the detention of patients who default on TB treatment, the NTLD Program released the TB Isolation Policy in 2018. The policy aims to act as a guide for health workers in instances where isolation is deemed appropriate, noting that: this should be a last resort; it should be non-punitive, non-discriminatory and respectful of human rights; there is a right to appeal the decision of isolation; and there must be respect for informed consent of refusal of treatment in isolation (unless this constitutes a potential public health concern) (Ministry of Health, 2018). Criteria are laid out for isolation as well as standards of care for patients in isolation. Despite policy efforts, in-country interviews indicated enforcement remains an issue at a local level as described below.

Human Rights-related Barriers to TB Services

This section of the report focuses on specific barriers experienced by relevant key and vulnerable populations in accessing TB services. Broadly these barriers include: punitive laws, policies and practices; stigma and discrimination; gender inequality; poverty and economic and social inequality, as well as barriers concerning insufficient availability and accessibility of services and a lack of information about TB transmission and treatment. Each subsection below includes a descriptive analysis of the nature and direct and indirect impacts of barriers in the context of TB.

(a) Punitive Laws, Policies, and Practices

Some of those interviewed felt that Kenya's legal environment may deter TB patients from seeking care and treatment because of existing provisions that criminalize and stigmatize the illness. For example, Section 18 of the Public Health Act, 1921 criminalizes non-reporting of a person who is infected with TB. This reporting obligation is placed on family members, medical practitioners or any other person who is aware of the condition. (KELIN, 2018i).

Section 27 of the Act permits medical providers to remove and confine any person in isolation, by an order of a Magistrate. This form of medical detention can continue until the medical provider is convinced that confined person is infection free. In the past, TB patients were incarcerated for sentences of up to 7-8 months under the Public Health Act for “failure to adhere” to their TB treatment, until the High Court declared the arrest and detention of people with TB unconstitutional in 2016. (KELIN, 2018i) The Court ruled to issue a circular to public health officers stating that section 27 should not be used to confine TB patients in prisons. The Government was also directed to commence the process of developing a policy on the involuntary confinement of persons suffering from infectious diseases (TB included) that is in line with international standards (UNDP and StopTB Partnership, 2017). In compliance with the court orders, the Ministry of Health through the National Tuberculosis, Leprosy and Lung Disease Program developed a TB Isolation Policy, which was published in June 2018. Despite this positive development, challenges remain in ensuring that everyone is aware of the new policy and implementing it appropriately; there have been instances of detention of people with TB since the policy was enacted and ongoing monitoring of its implementation is key.

Section 28 of the Act criminalizes willful exposure of disease to the public, making someone else expose the infection to the public or providing bedding or clothing known to have been exposed to such an infection. It also makes it unlawful to enter public premises without notifying the owner of such an infection, and such person may be required to pay for disinfection.

Sections 18, 27 and 28 of the Act have been used to discriminate against people living with TB. As noted above, prior to 2015, there were reported cases of incarceration for people living with TB for failing to complete their treatment or for other similar reasons. This also exposed other prison inmates to such infection. While, some of these provisions may be necessary for maintaining public health, lack of clear guidelines leaves them open to misuse resulting in a serious breach of privacy, confidentiality and consent. Moreover, these provisions increase the stigma surrounding TB.

Due to lack of correct information and knowledge, TB is sometimes considered as non-treatable, and those living with TB are marginalized by society. Additionally, lack of information has affected people living with TB. There have been reports where people living with TB have failed to complete the course of treatment since they stopped taking their medication as soon as they started feeling better. The result of these punitive provisions and sufficient lack of information and understanding of the disease leads to people to avoid clinics and treatment for fear of violations of their privacy, confidentiality, and even their freedom (KELIN, 2018i).

Despite the creation of the TB Isolation Policy in 2018, it appears the policy has not yet been implemented at the community level (key informant interview 18). There are reportedly still many arrests of people living with TB in the community who default on their treatment (key informant interview 65). Key informants from Mombasa reported that those who default on TB treatment are still arrested as there are no structures in place or proper health facilities to manage patients (key informant interview 10). Key informants reported that some counties try to

force TB patients to take medication and noted there are no clear guidelines or policy to manage those who default on their treatment resulting in communities getting court orders to force TB treatment (key informant interview 6).

Although there appear to be different levels of understanding of TB-related policies among law enforcement, troublingly, a member of law enforcement interviewed in Nairobi asserted that police can arrest those who default on TB treatment, force them to take medication and hold them in isolation (key informant interview 71).

TB survivors in Nairobi explained that punitive practices also occur at health facilities noting if a patient misses two appointments, they are labeled a defaulter and sent to the end of the treatment line without exception (focus group discussion 13).

(b) Stigma and Discrimination

The stigma around TB has been observed to be detrimental to the identification and treatment of cases. In some instances a lack of understanding about the etiology of TB has resulted in unnecessary isolation and discrimination against individuals with TB (key informant interview 66), (WHO, 2006). Discrimination was reported by TB survivors in Nairobi citing examples such as denial of employment. Stigma and discrimination within health facilities were also reported, including poor treatment by health care workers, TB patients being sent to sit far away and being blamed for late presentation at the health facility (focus group discussion 13). The location of the TB clinics within a health facility is reported to be associated with feelings of stigma and discrimination: a key informant in Nairobi reported that TB clinics are generally located in the run-down section of the health facility resulting in stigma because not only is the clinic easily identifiable but also because of a perceived under-prioritization of TB as health facilities do not allocate funding for the upkeep of TB clinics (key informant interview 50). All of these factors were reported to act as barriers to accessing health services.

Across different settings and population groups, there is a general belief that those who are diagnosed with TB are also living with HIV, further intensifying the stigma associated with a TB diagnosis (focus group discussions 2, 13, 14, key informant interviews 66, 67, 69, 75). Some TB survivors suggested there is a need for more TB programs for people affected by TB other than people living with HIV (focus group discussion 13). A key informant from an NGO in Nairobi also reported TB stigma is a result of a perceived association with poverty and weakness (key informant interview 69).

Stigma and discrimination associated with TB appear to carry long-term impacts. TB survivors in Nairobi indicated high levels of self-stigma among people with TB and noted that few survivors speak publicly about their experience (focus group discussion 13). Similarly, a key informant interview with a TB survivors and educators in Nairobi reported that survivors of TB continue to be stigmatized by their community even after they have recovered from TB (key informant interview 68).

The nuance of TB-related stigma is still not very well-understood,²¹ which itself creates a barrier to designing effective policies and programs to respond to them. Additional data, perhaps using the Stop TB 'TB Stigma Assessment' tool, would be useful for informing local, county and national-level responses to TB-related stigma and discrimination (Stop TB Partnership, 2019a).

Women Young women in Nairobi reported that health care workers generally do not provide information about TB to young people, and often accuse young people living with HIV of not adhering to their ART if they contract TB (focus group discussion 10).

Health care workers Diagnostic challenges and stigma are barriers to regular TB screening for health care workers (KELIN, 2018j). Health care workers may perceive stigma more heavily (and thus avoid screening or treatment, especially from the facilities they work at), because they see the impact of illness on their patients, internalize discrimination from their co-workers toward patients, and feel pressure to be healthy in order to perform their professional duties (KELIN, 2018j). It was reported that health care workers are not compensated if they contract TB through occupational exposure, and in some instances, those who contract TB may lose their jobs (focus group discussion 12). Key informants echoed these findings, noting that most health care workers do not attend TB screening, instead often self-diagnose and often treat their symptoms through self-diagnosis in denial of an official TB diagnosis. They described emotional distress among health care workers who are diagnosed with TB being common and noted that many default on treatment. High levels of stigma were reported among health care workers as well as stigma associated with the use of respirators used to prevent the spread of TB (focus group discussion 12). Key informants in Nairobi indicated there are gaps in self-reporting TB infection among health care workers. Due to stigma, health care workers opt to seek treatment at a facility different than where they work, and do not disclose the infection to their employer (key informant interview 57).

Findings for health care workers in prisons were similar to those in other health facilities. Key informants from a prison reported high levels of stigma among health care workers working within the prison and prison staff resulting in low levels of screening for TB (key informant interview 31).

(i) People who inject drugs

People who inject drugs in Mombasa reported that when members of their community seek treatment for multi-drug resistant TB (MDR-TB) they often face double stigma at health facilities, especially if they are experiencing withdrawal symptoms (focus group discussion 1). A focus group discussion with TB champions in Kitui reported people who use drugs face additional challenges to treatment adherence because of side effects, drug interactions and a lack of support resulting in defaulting (focus group discussion 14).

²¹ Some useful studies are forthcoming, including from the APHRC on pastoralist communities, but findings are currently only in pre-print (i.e. not peer-reviewed) format and therefore not deemed suitable for inclusion as a basis for informing policy and programming. It will be useful to talk to those involved to learn from their work to date.

(ii) Men who have sex with men

Men who have sex with men in Mombasa reported experiencing stigma at health facilities, and as a result some do not access TB-related health services due to fear of stigma and discrimination (focus group discussion 2).

(c) Gender Norms

A recent TB and gender assessment in Kenya identified gender-related barriers to TB care for both women and men. The assessment found that men face societal pressure to be perceived as “strong and macho”, which acts as a barrier to seeking treatment for symptoms that are thought to be insignificant, such as cough. Additional gender-related barriers within health facilities were also identified: long wait times were reported to be a barrier for men to seek care as they are often employed during health facility operating hours and fear losing their jobs or lost wages. The report revealed that the gender of the health care workers can also act as a barrier to care as in some cultures men and women are not comfortable seeking care from the opposite sex (KELIN, 2018g). Similar findings were reported by key informant interviews from NGOs in Nairobi noting the limited hours of TB clinics, perceived severity of symptoms (key informant interview 67) and the perception that seeking medical treatment is a sign of weakness to be barriers for men to access services (key informant interview 69).

Women often need permission from men to seek care, and the care for children and men is prioritized over that of women. In addition to lack of decision-making power, lower levels of education and financial resources among women act as barriers to care for women (KELIN, 2018g). A key informant interview with a TB survivor and educator in Nairobi echoed this sentiment noting that, if a woman’s husband is away working, she will delay seeking treatment until his return to first obtain his consent (key informant interview 68).

(d) Underlying Poverty and Economic Inequality

Poverty and economic inequality are barriers to accessing TB services, in particular for key populations. A key informant from Mombasa indicated that congested housing conditions in many areas, which are linked to underlying poverty, increase vulnerability to TB (key informant interview 4). Those who are economically disadvantaged tend to delay seeking care which perpetuates the spread of TB (key informant interview 1), (Mauch et al., 2011). For those needing treatment, it can be difficult to schedule an appointment at a time that does not infringe on work, especially for informal or casual laborers who are paid per day and have very little job security (key informant interview 69), (KELIN, 2018g).

Economic challenges are magnified by the costs of drugs and extra tests, as well as non-medical costs such as transportation to hospitals (key informant interview 4) and

accommodations by family members to treat the ill patient (Ministry of Health, 2017a). Transportation and health spending, like diagnostics and nutritional/financial support, constituted the highest costs. Although health services are described as “free”, a key informant reported that in practice they are not (key informant interview 50).

Respondents reported that NHIF does not cover the cost of x-rays or some medications. In addition, patients may be expected to pay out of pocket for health services and wait up to several weeks for NHIF reimbursement (FDG10). Among TB patients, NHIF coverage has been found to be 13.6% (Ministry of Health, 2017a). This is particularly important for people with MDR-TB; 26.5% of people with drug-responsive TB incur financially catastrophic expenditures (defined as costs that exceeded 20% of their annual household consumption expenditure) while 86.4% of people with MDR-TB incur such expenditures. “Direct medical costs”, the cost of consultation and testing, was the lowest reported expenditure. The largest expenditure was found to be “direct non-medical costs” such as transportation followed by “indirect costs” such as loss of wages (Ministry of Health, 2017a).

Some TB survivors in Nairobi indicated that government health facilities are inflexible about payment, while private health facilities or pharmacies allow for flexibility in payment to cover the cost of drugs, resulting in higher utilization of private services (focus group discussion13). Compounding the issue is that TB affects individuals at their most economically-productive age, which can inflict a serious burden on families (Mauch et al., 2011).

A focus group discussion with TB survivors in Nairobi revealed that they experienced side effects from medication during treatment, and though TB treatment is reportedly free, the cost of treatment for side effects and associated complications not (FDG13). A key informant from the government in Kisumu cited side effects from TB medication as a reason why patients default on their treatment (key informant interview 66).

Food insecurity was identified by a wide range of participants as a barrier to TB treatment adherence (focus group discussions 4, 13, 14, 15, key informant interviews 4, 44, 56, 66, 67). The increase in appetite caused by TB treatment coupled with a lack of access to food and proper nutrition can cause people to default on their treatment (focus group discussion13, key informant interview 4). One key informant explained that those who receive supplemental nutrition through government programs share with their families noting: “We really can’t treat without acknowledging family” (key informant interview 66). Nutritional support baskets are designed around the individual patient but are, in reality, being shared with other household members, which means that challenges around adherence may still remain. A focus group discussion with TB champions in Kitui revealed hunger is a persistent issue in the county due to the arid and semi-arid nature of the area. As a result, food insecurity is a major factor in the reportedly high TB default rates in the county (focus group discussion 14).

(e) Availability and Accessibility of TB Services

The limited availability and accessibility of quality healthcare is reported to be a barrier to utilizing TB health services in Kenya (key informant interview 1, focus group discussion 14). A focus group discussion with TB champions in Kitui reported that due to the large size of the county and geographic distribution of major health facilities, some people have to travel up to 100KM to access TB services. Sub-county facilities reportedly lack personnel and capacity including TB specialists, diagnostic tools and medication (focus group discussions 14, 15). A focus group discussion with people living with HIV in Kitui reported GeneXpert testing is only available in two health facilities in the county (focus group discussion 15). Women, children and the elderly are reportedly the most disadvantaged by this issue of physical accessibility (focus group discussions 14, 15). Poverty and poor infrastructure increase the challenges of transportation and security concerns were reported when accessing facilities at night (focus group discussion 14). The security concerns about accessing facilities at night only apply for the ten health facilities in Kitui that are open at night, seven of which are private clinics (Ministry of Health, 2020).

A focus group discussion with TB survivors in Nairobi revealed that health care worker knowledge about TB treatment guidelines is low. Respondents also indicated that communities lack trust in the government-run health facilities due to frequent drug stock outs. TB clinics are often staffed by community health volunteers, not health care workers, and participants noted health care workers may not want to work at TB clinics due to stigma (focus group discussion 13). A key informant from the NTLD-Program also noted deficits in quality of care due a lack of staffing at health facilities (key informant interview 66). A key informant from an NGO in Nairobi reported similar health care worker shortages citing fear of TB infection among health care workers as the cause (key informant interview 67). TB survivors in Nairobi and people living with HIV in Kitui reported delays in TB diagnosis after testing (focus group discussions 13, 15). Participants in Nairobi indicated that results can take up to a month without explanation resulting in multiple trips to the health facility. In addition, there is reportedly no follow-up mechanism for patients who miss appointments and a lack of counselling to accompany a positive TB diagnosis at the health facility (focus group discussion 13). A government key informant in Kisumu indicated that demand for TB services has increased resulting in a wait of up to five- days for x-rays. This issue has reportedly worsened since the launch of the county-wide Universal Health Coverage pilot test which has increased demand for services (key informant interview 66).

A range of health service users suggested that low health seeking behavior might be attributed to the lack of services available as people are turned away from TB screenings due to a lack of diagnostic supplies such as GeneXpert cartridges or staff shortages (key informant interview 18, focus group discussion 7).

(f) Lack of Information

Lack of information about TB transmission and prevention was reported by key informants in Nairobi and Mombasa as well as focus group discussions in Kitui (key informant interviews 1, 4, 68, 69, focus group discussions 14, 15). A TB survivor and educator in Nairobi reported that some women were unaware TB is airborne and believed washing dishes used by someone with TB with hot ash was an effective means of prevention. In addition, they noted health care workers may not know all symptoms of TB resulting in misdiagnosis at health facilities (key informant interview 68). Mothers of children under five years old in Kisumu reported a lack of information about TB, noting better availability of information and services for HIV and malaria compared to TB (focus group discussion 7).

A lack of information among pharmacists, traditional healers and private health facilities was also noted in a focus group discussion. Participants reported self-medication with cough suppressant is very common and in informal settlements people tend to visit a traditional healer who treats symptoms with herbs. This contributes to delayed presentation at a health facility and possible disease transmission. In addition, they noted further delays in health seeking behavior due to religious institutions advising people to pray rather than taking medication (focus group discussion 13).

(g) Barriers for Key Populations

(i) Mobile populations

Mobile populations face a number of barriers that make them uniquely susceptible to TB, or unable to adhere to treatment programs. Kenya has two of the largest refugee camps in Africa – Dadaab and Kakuma – and is experiencing a record amount of migration. These settlements are informal and overcrowded, with poor ventilation, nutrition, and access to healthcare (Key Populations Brief, 2016). Other risk factors for TB in the camps may include stress, poor social capital, animal husbandry, risky behaviors like smoking and alcohol use, and interaction with other migrants from countries with a high burden of TB (KELIN, 2018j). As mentioned above, MDR-TB is quite high among refugees in Kenya. Control of TB in Dadaab requires coordination with programs in Somalia given how many of the refugees are of Somali origin (National Tuberculosis Leprosy and Lung Disease Program, 2016).

Nomadic and semi-nomadic tribes, as well as those whose dwellings still reflect the traditional dwellings of a time when they were nomadic, may be at increased risk for TB. There are more cases of TB among the Maasai than any other ethnic group in Kenya. Contributing factors include the traditional housing design (with very little ventilation), indoor cooking, and consumption of raw milk and uncooked meat. Accompanying cattle to different parts of the country can also exacerbate onward transmission (key informant interview 68). Uptake of TB testing and treatment services remains low among this population.

(ii) Prisoners and incarcerated populations

In Kenya, prisoners have been identified as a population who are at a high risk of TB (KELIN, 2018i).

Prison overcrowding (key informant interviews 58, 65) and inadequate infrastructure are reported to be issues for TB prevention and control (key informant interview 40). Informants working in prisons in Kisumu reported that the maximum-security prison was built for a capacity of 600, but currently holds 2,300 prisoners (key informant interview 58). A key informant in Nairobi indicated almost all prisons are holding two to three times capacity without space for isolation (key informant interview 65). Recent research found that overcrowding, poor ventilation, and lack of access to diagnostic tests are large factors that contribute to the disproportionate level of TB in prisons (KELIN, 2018i). In line with this, key informants from the prisons service reported that most prisons do not have adequate infrastructure for infection prevention or control as most prisons do not have segregation facilities (key informant interviews 31, 40). A key informant indicated that the prison where they work does have an isolation room where prisoners with TB are isolated for two months; at the time of interview, it was holding six-seven people (key informant interview 31).

Concerns regarding the availability and quality of health services in prisons were reported by key informants (key informant interviews 31, 58, 65). Key informants reported that many prisoners do not have identification cards and as a result cannot obtain health insurance, noting that insurance fees are not waived for prisoners (key informant interview 6). Similar challenges were reported by another key informant indicating that without identification, prisoners cannot register for NHIF (key informant interview 58). A key informant reported that there are fewer than 60 health facilities serving 110 prisons. Some prisons do not have onsite health facilities and share facilities with other prisons. The health facilities that are available are reportedly understaffed, lack adequate supplies (key informant interview 65), face delays in getting TB tests results and have equipment that is often broken (key informant interview 58). These findings align with research that found that prison staff may not be appropriately trained to recognize the symptoms of TB or prioritize inmates' transportation to a health facility for screening (KELIN, 2018i). At a prison in Nairobi, prisoners are generally not screened for TB on the day of intake or by a health care worker. Instead, within 72 hours they are screened in the prison health facility and incidence rates are reported to be high (key informant interview 31). Insufficient nutritional support for TB patients in prisons was also reported as a concern (key informant interviews 31, 58).

Conversely, key informants working with prisons in Kisumu reported current TB cases are low and all inmates are screened and treated, including isolation and nutritional support, as needed upon intake (key informant interview 58). There was one key informant in Mombasa who reported not seeing any barriers to TB care for prisoners. The informant reported the prison had screenings for TB upon intake, an isolation ward, and regular screening for signs of illness (key informant interview 2).

Maintaining patient confidentiality was reported to be a problem in prisons (key informant interviews 31, 58). Key informants working in a prison indicated that staff do not have training in medical records management and when they are short-staffed, prisoners help manage medical records. Informants noted there have been instances where patient files have “disappeared” (key informant interview 31). In addition, there is no linkage of medical records from outside health facilities to the prison health facility, resulting in possible treatment gaps for new prisoners. Similarly, there is no program for follow-up to outside health facilities for prisoners who are released (key informant interview 31). Transfers between prisons do not seem to constitute a risk for treatment interruption as there is an information-sharing system in place to mitigate against this (key informant interview 65).

The high rate of turnover, alongside the overcrowding, exacerbates TB transmission. (key informant interview 40) Furthermore, if women in prison have children under the age of five the child can remain with them in the cell; if the woman has TB, the child, many of whom have not received the BCG vaccination, still stays in ‘isolation’ with her (key informant interview 40).

(iii) People living with HIV

Awareness of TB among the general population in Kenya is high but, according to the 2012-2013 Kenya AIDS Indicator Survey, fewer than half of participants knew that TB was curable in persons living with HIV (Mbithi et al., 2014). Lack of knowledge among the affected populations constitutes a barrier for access to healthcare.

(iv) Occupational risks without protections

A focus group discussion with health care workers in Kisumu reported working in poorly ventilated spaces with no isolation wards for MDR-TB patients as well as low TB prevention and control sensitization among health care workers due to lack of funding and human resources (focus group discussion 12). As noted above, health care workers in Kisumu reported even if protections are available, there is a high level of stigma associated with the use of respirators used to prevent the spread of TB (focus group discussion 12).

Findings for health care workers in prisons were similar to those in health facilities. Key informants from a prison reported there is no attention paid to TB risk for prison staff (key informant interview 31). Key informants from a prison in Kisumu indicated health care workers within the prison do not have access to vaccinations or face masks and work in poorly ventilated spaces (key informant interview 58).

Existing Programs to Address Human Rights-related Barriers to TB Services

(a) Introduction

There is significantly less programming specific to removing human rights-related barriers to TB services than there is for HIV services. As might be expected, even though the HIV and TB programs within national structures are separate, there is substantial integration of programs to

address human rights related barriers to HIV and TB services, with many programs concurrently addressing both issues. Those have been included in the HIV section above.

As with HIV, it is important to recognize the heterogeneity of key populations in the context of TB: different populations may be included in different counties (e.g. fisherfolk are relevant in some but not all counties) and, within each key population, risk profiles may vary (e.g. by type of employment). All of this has implications for the type of programming that is needed to overcome barriers to accessing services.

This section seeks to provide illustrative examples of some of the different types of work being carried out.

(b) Reducing Stigma and Discrimination

The National Strategic Plan for Tuberculosis, Leprosy and Lung Health 2019-2023 identified the implementation of programs to reduce stigma and discrimination related to TB as a strategic intervention to remove legal, gender, and human rights barriers to TB services. Stigma and discrimination reduction among health care workers, within the workplace and at the community level are specifically identified as focus areas (Ministry of Health, 2019).

A range of organizations are implementing programs in the area of community mobilization and education on TB-related stigma and discrimination in different parts of the country. Broader community advocacy initiatives to raise awareness about TB and the related stigma and discrimination have been carried out by the Supreme Council of Kenya Muslims (SUPKEM) and Program for Appropriate Technology in Health (PATH) among others (key informant interview 13), (L. Ferguson, Alva, S., 2019). The NGO, Talaku, although driven almost entirely by one individual, employed a range of methods to tackle TB-related stigma and discrimination in Kajiado County including advertisements on public transport, community education through home visits and community mobilization to adjust the Maasai living environment to be less conducive to TB transmission (e.g. manyatta design, cooking styles) (key informant interview 68).

Within WOFAK's workplan in Busia County under the current Global Fund TB grant (2018-2020), one of the key outputs is "reduced barriers to TB treatment access including stigma and discrimination" (WOFAK, n.d.-b). This is to be achieved through a range of activities including the development and distribution of IEC materials, social mobilization and sensitization, quarterly community open dialogue sessions and TB advocacy sessions. All of this is to be done with a focus on most-at-risk populations (defined as people living with HIV, healthcare workers, mobile populations, prisoners and contacts of TB patients) and with a view to strengthening community systems. At the time of data collection, no information could be found on progress with implementation.

WOFAK has already carried out dialogue sessions with religious leaders, community leaders, opinions leaders, chiefs and police in Nairobi to promote access to TB services, focusing on the importance of access to information and services for key populations (key informant interview 55). The International Network of Religious Leaders Living with or Personally Affected by HIV and AIDS (INERELA) has also carried out advocacy with religious leaders to promote access to TB services, particularly for women and children (key informant interview 56).

Some drop-in centers (DICES) now offer TB screening services in addition to their traditional HIV services. The DICES are known for providing “friendly” services for key populations, including sex workers, men who have sex with men and fishermen, and are open 24 hours a day. Anyone diagnosed with TB is meant to be linked to TB treatment services (KELIN, 2018g). In Mombasa, Kilifi, Kwale, Lamu and Taita Taveta, the non-governmental organization Afya Pwani has done some capacity building in these DICES to reduce stigma and discrimination (key informant interview 1).

(c) Reducing Gender-based Barriers to TB Services

Due to the high male burden of TB in Kenya, programs have been developed to better target men. Some professions that tend to be male dominated such as mining, *boda boda* driving and the *matatu* industry have been the target for interventions and occupational-based TB screenings. In Kisumu, TB screenings have been conducted at a quarry during the workday, which has successfully identified some cases. A description of the plan to ensure privacy and non-discrimination, both critical in this type of programming, was lacking (KELIN, 2018g). In 2017, the NTLD Program in collaboration with StopTB organized a two-day TB sensitization workshop for the youth organization BLAST (Building Lives Around Sound Transformation) and Boda Boda Riders in Nairobi. Using the tagline “Mulika TB Maliza TB” participants were trained on TB prevention, treatment and control (Ministry of Health, 2017b).

In Homa Bay and Turkana, the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) provided support for men to become TB champions, building their capacity to mobilize family members and setting up support groups for TB (key informant interview 49).

Kisumu county has made some efforts to increase the number of male community health volunteers (who are more often female) so as to increase their acceptability to men who, as just noted, bear a higher burden of TB morbidity than women (KELIN, 2018g).

In 2015, Stop TB in partnership with the Global Fund, UNAIDS, the Global Coalition of TB Activists (GCTA) and AIDS Strategy, Advocacy and Policy conducted an international HIV/TB Gender Assessment Workshop in Nairobi. The workshop’s aim was “to strengthen the capacity of TB activists and gender equality advocates to integrate gender equality perspectives in TB and HIV national program planning” (Stop TB Partnership, 2015a). Participants were introduced to the TB/HIV Gender Assessment Tool with a view to ensuring they could use this to help inform gender responsive TB programming move forward. This tool was one of the tools used,

with support from the Stop TB Partnership, as part of the TB community, rights and gender assessment.

To help overcome some of the specific challenges faced by female sex workers in accessing TB services such as inaccessible opening hours and long distances to services, NGOs, including Hapa Kenya and COSWA, have done sensitization with female sex workers and helped improve accessibility of services (through increased staffing, the provision of transportation, night clinic hours and regular outreach services) (focus group discussion 5).

The needs of trans people infected with TB (both with and without HIV coinfection) are given very little attention in national policies and service delivery. For example, there is no facility to record anything other than 'female' or 'male' in the TB registry nor any space to record information such as the client taking hormone therapy. The only study found with information on TB among the transgender community identified barriers to accessing services as competing priorities (e.g. gender affirmation services seem more important than accessing TB services), self-stigma/fear of stigma within health services and fear of breaches in confidentiality by health workers (KELIN, 2018g).

(d) TB-related Legal Services

KELIN recently set up legal aid clinics which provide direct legal assistance to individuals living with TB and/or HIV. Many of their cases relate to disputes which are civil in nature, including land and property matters, ownership, custody and maintenance, discrimination and succession. KELIN also provide ad hoc legal clinics at relevant conferences, such as the Maisha conference. In 2018, AMREF, KELIN, and the NTLD Program, with support from Global Fund, conducted a sensitization workshop for 76 lawyers on TB and human rights. The program focused on 3 regions: Eastern/Nairobi, Coast and Western/Nyanza. The purpose of the workshop was to develop a better understanding of TB and the law related to TB and human rights issues. The workshop aimed to promote participation of legal practitioners and recognize TB-related rights violations (KELIN, 2018e), (key informant interview 67). The challenge is how to support the costs that lawyers incur doing *pro bono* cases (e.g. transportation, photocopies, court fees) as without this support the sustainability of this work is in question.

Under the current Global Fund grant (2018-2020), AMREF, with technical support from KELIN, recently carried out a 3-day training on TB for over 100 lawyers from Mombasa, Machakos and Kisumu. AMREF and KELIN have also collaborated to train paralegals. A key informant noted that there is a general human rights training handbook for paralegals, which constitutes a 2-week training, but that it would be useful to add 3-4 days on HIV and TB that should be completed before paralegals can become accredited by the National Legal Aid Institute (key informant interview 38).

(e) Monitoring and Reforming Policies, Regulations and Laws that Impede TB Services

In 2016, KELIN successfully litigated in the High Court for the rights of people living with TB. Due to the Constitutional Petition filed by KELIN for people incarcerated due to their TB status, the High Court decided in 2016 that the practice of isolating people living with TB in prisons for the purpose of treatment under Section 27 of the Public Health Act is unconstitutional and unlawful (KELIN, 2018j). A MOH Policy Directive on the Imprisonment of TB patients resulted from this judgment and states that, if such isolation is necessary, the Chief Officer of Health must get permission from the Court or Magistrate, and that any isolation of people living with TB must occur in health facilities in a proper manner which protects the rights of the person living with TB and the general public (KELIN, 2018i).

In 2018, KELIN published an assessment of the TB-related legal environment. This can be used to help inform legal reform efforts and target advocacy to improve the TB-related legal environment (KELIN, 2018i).

iMonitor is an app that is being used by Amref in collaboration with national and county governments, TAC Health Africa and National Empowerment Network of People living with HIV/AIDS in Kenya (NEPHAK) as part of monitoring the integrated TB, HIV and malaria activities being implemented in the three sub-counties of Rangwe, Emuhaya and Lungalunga (Kwale, Vihiga and Homabay Counties respectively). The system allows users to share feedback on their experiences at health services so that local authorities can address any issues. Between January 2017 and March 2019, national and county health management teams were sensitized on the use of iMonitor, and 30 CSOs and 60 community health volunteers were trained as users and provided with smart phones installed with iMonitor+. Of the 866 issues reported, 10% related to human rights (Kiptai et al., 2019). This technology allows for timely identification of rights violations within health facilities and alert of appropriate authorities. A follow-up mechanism to ensure action and accountability is critical to ensure effectiveness. This might be expanded to additional health facilities/counties and to venues other than health facilities e.g. for use in other social services, employment etc.

Stop TB has carried out a series of community level discussions on TB and human rights, as well as intervention in cases of violations. They have established a national network of TB advocates to help train and sensitize on human rights and monitor violations (key informant interview 69).

The social accountability work of the non-governmental organization URAIA that focuses on community capacity building on the right to health as well as measuring/rating health services is a useful model even as it is not TB specific. With additional focus on TB, and perhaps greater involvement of the TB community, there is potential to scale this up as an additional means of increasing accountability around TB (key informant interview 37).

(f) Legal Literacy (“Know Your TB-related Rights”)

The National Strategic Plan for Tuberculosis, Leprosy and Lung Health 2019-2023 identified the implementation of programs to improve legal literacy as a strategic intervention to remove legal, gender, and human rights barriers to TB services (Ministry of Health, 2019).

Working with local partners, KELIN has carried out a series of county dialogues on HIV, TB sexual and reproductive health and human rights. These dialogues provided fora in which people with TB could articulate their human rights-related grievances and, in addition, raised awareness about relevant rights and corresponding duty-bearers, with the latter also present at the dialogues (KELIN, 2018a, 2018b, 2018d). Moving forward it will be important to track the extent to which duty-bearers follow up on the issues raised during these dialogues with responsive policies and programs.

Between May 2018 and May 2019, with funding from Stop TB, KELIN worked in six informal settlements in Nairobi to increase knowledge on rights-based approaches to TB, to create awareness on TB and human rights among health care workers and county health management teams, and to facilitate access to justice for communities affected by TB whose rights have been violated. (Stop TB Partnership, 2019).

Various civil society organizations, including Pema Kenya, Hapa Kenya, Tamba Pwani, Amkeni and Ukweli, have done human rights training and sensitization in the coastal areas targeting men who have sex with men that have included TB-related information (focus group discussion 5).

Sensitization of law-makers, judicial officers and law enforcement agentsThe National Strategic Plan for Tuberculosis, Leprosy and Lung Health 2019-2023 identified the sensitization of law makers, law enforcement and health care workers as strategic interventions to remove legal, gender, and human rights barriers to TB services (Ministry of Health, 2019).

Although KELIN’s lawyer training focuses on practitioners with interest or experience in working with people living with HIV, the training also covers topics such as TB. The aim is to facilitate reforms in the law and increase access to justice. From 2012-2017, the program reached 91 judges and 112 judicial officers (KELIN, 2018f). Testimonials suggest that there have been changes in police attitudes and behaviors toward key populations, particularly in the Mombasa area. KELIN has also partnered with Kenya Prison Services-AIDS Control Unit to provide training to senior regional law enforcement officers for better techniques for responding to HIV and TB. A meeting took place in July 2014 in Nairobi with top ranking officials of Kenya Prisons Service, the national HIV and TB programs, UN agencies and NGOs. The report notes a wide range of key points including the need for: trainings to strengthen the capacity of Kenya Prisons Service staff; scale-up of HIV and TB interventions for prisoners and incarcerated populations; review of laws and prison policies to align them with the Constitutional provisions to advance human rights; inclusion of prisoners as key populations in national HIV and TB responses; introducing condoms in prisons; and strategic partnerships (KELIN, 2014c, 2018f).

A few months later, KELIN, in partnership with the Kenya Prison Service, and working in close consultation with a range of partners, including UNDP, NEPHAK, NACC, NASCOP and UNAIDS, carried out a capacity-building workshop for senior prison officers from Kilifi, Kisumu, Mombasa and Nairobi counties and additional prison officers and law enforcement agents from other counties on human rights and the law in relation to HIV and TB in prisons. The workshop aimed to increase awareness of the role of the law and law enforcement agents in protecting the rights of people living with HIV and TB within their custody, to enhance commitment to implementing protections to address sexual and gender-based violence in prisons, and to engender commitment to specific proposals to advance rights-based interventions in this context (KELIN, 2014a).

KELIN also held a forum in September 2016 for 83 participants some of which were senior law enforcement officers from ten countries in Southern, East and Central Africa in Nakuru County. The purpose of the forum was to strengthen regional and national evidence-based law, policy and strategy to improve access to HIV and TB services to key and vulnerable populations (KELIN, 2016a).

(g) Training of Health Care Providers on Human Rights and Ethics Related to TB

KELIN has held trainings for health care providers on human rights and ethics related to TB, often also covering HIV. This includes a training workshop for 22 people in Kakamega in 2014 and another one in Nairobi in 2016 (KELIN, 2016a). The latter, also mentioned above, included health care workers and senior law enforcement officers (KELIN, 2016a).

(h) Ensuring Confidentiality and Privacy

No programs were identified that were specifically and exclusively focused on ensuring confidentiality and privacy in the context of TB.

(i) Mobilizing and Empowering Patient and Community Groups

In 2010, the Stop TB Partnership launched its TB REACH program through which it funds private providers who engage in innovative technologies and ways to fight TB. The International Medical Corps (IMC) with the help of community health workers and pharmacies successfully tested more than 60,000 people in Mombasa County within the first 9 months. In the same project, Kenyan Association for the Prevention of TB and Lung Diseases (KAPTLD) set up screening centers in the informal settlements of Nairobi, with the help of past TB and HIV patients to work as screeners. To improve communication and to draw more attention, KAPTLD

has held theatre and music performances promoting screening and health education. They engaged with local chemists to identify about 18,000 people with TB within the first nine months of the project (Stop TB Partnership, 2011).

While most organizations focus on the clinical aspects of TB screening, contact tracing and treatment, KELIN has worked to empower communities to create conversations on TB and human rights, empower people with TB through legal literacy, and to ensure their meaningful engagement including in decision-making fora such as the CCM.

A Global Fund grant to steer the country toward the achievement of the TB Millennium Development Goals in line with the Global Stop TB Strategy has also worked to strengthen primary healthcare through community and patient empowerment. The program began in 2011 and by 2013, had reached 2,947 TB patients with health education messages through home visits (The Global Fund, 2014). Over 2,600 community health workers and community health extension workers were trained on topics including screening TB patients, community-based DOTS and cough monitoring (The Global Fund, 2014). Approximately 4,500 households with someone with a positive smear test for TB were reached for contact tracing. By the end of 2016, the percentage of total notified cases that were referred by the communities had increased from 6.4 to 9.2% (The Global Fund, 2017a).

Between 2014 and 2015, a Stop TB Partnership project in Nyanza worked to improve case detection at the facilities, through home visits, increasing contact training and detection among people living with HIV. This also involved training technicians, clinicians and community health workers. By the end of 2015, the project had successfully screened 464,514 people in health facilities and communities with 981 TB cases detected (Stop TB Partnership, 2015b).

In 2018, Reachout conducted active TB case finding among people who inject drugs in 'hotspots' in Mvita, Nyali, Likoni, Changamwe and Jomvu sub-counties of Mombasa county, which is where they offer harm reduction services. Through peer educators and outreach services using clinical assessments, chest x-rays and sputum sample collection, over 600 people were screened (Trust, 2018b).

A safety net program has been initiated in Kenya, operated by the NLTD Program, with support from the Global Fund, to support people living with TB with cash transfers in the amount of KES 6000 to all DR-TB patients. This is available to all people living with DR-TB, who have already enrolled for treatment.

Stop TB Kenya, in collaboration with the National TB Program has worked to empower TB survivors to advocate for social protection of drug resistant patients (key informant interview 69).

(j) Programs in Prisons and Other Closed Settings

In 2007/08, the National Leprosy and Tuberculosis Control Program collaborated with the Kenyan Medical Research Institute and Centers for Disease Control and Prevention (CDC) to provide demonstrations for TB control in Kamiti and Kodiaga prisons by introducing programs such as screening of new inmates (WHO, 2009). In 2017, the NLTP reported that they implemented TB screenings for all prisoners and new inmates across the country (Ministry of Health, 2017b).

In 2013, a regional workshop was conducted by UNDP and KELIN for senior law enforcement officers from six countries, including Kenya, on HIV, TB human rights and the law. Nine Kenyan police officers and 9 Kenyan prison officers attended the workshop. At the end of the three-day workshop, the attendees came up with action plan for their countries. A need was felt for engagement of law enforcement officers through sensitization programs on the impact of HIV responses and other related issues such as TB. A consensus was reached toward effective efforts toward joint dialogues to enable a legal environment to support effective interventions for HIV and other diseases (KELIN, 2013).

In the Coast Region, the AIDS Control Unit of Kenya Prison Service has carried out some sensitization of prison staff on HIV and TB (key informant interview 17). Some prisons are currently training non-clinical officers to recognize the symptoms of TB to meet high demand for early referral, and information on TB is being provided to prisoners (KELIN, 2018i). WOFAK have also trained prison officers on TB and HIV as well trying to promote better quality services within prisons (key informant interview 3). Reachout has provided weekly legal support to both of the prisons in Mombasa, with two paralegal officers to meet with inmates.

HealthStrat, through its 'Transforming TB and HIV Prevention, Care and Treatment in Prisons' program (TACT), has built the capacity of Kenya Prison Services to provide comprehensive HIV and TB prevention, care and treatment services. HealthStrat has also trained some prisoners to look out for and report TB cases among other prisoners. To participate in this program, inmates are identified by the prison administration based on good conduct, ability to read and write and capacity to take role of leadership and mentorship. They should also have a prison stay of at least six months. They are then trained and mentored on identifying coughers with a clear system of referral and documentation. These are then taken through a 5-day TB Infection Prevention and Control training and are certified by the Ministry of Health under the TB Program (key informant interview 65).

When inmates are diagnosed with TB, they are put in "isolation" for treatment even as, in reality, there can be multiple inmates concurrently held in the isolation cell. If they are released part way through the course of treatment, part of their discharge process is to report to a local clinic for continued treatment (key informant interviews 65, 66). It has also provided prevention and treatment services for prison staff and their families as well as the inmates and, in some cases, surrounding communities. The HealthStrat project has reportedly improved access to and uptake of HIV and TB services. The number of Kenya Prison Services facilities offering care and treatment services increased from 27 in 2014 to 42 in 2018 (HealthStrat, 2019). A facility for

dealing with MDR-TB in prisons has been developed at the coast but that is the only one (key informant interview 40).

Key informants noted challenges arising from the lack of connection between prison health records and the Ministry of Health's health management information system (key informant interviews 2, 7, 31). Prison officers noted they had had some interaction with the county health staff for record management training but that more support was required (key informant interview 7).

8. Baseline Findings – Malaria

This section of the report focuses on findings relevant to malaria including the epidemiological context, political and legal environment, barriers to accessing services, and existing programs in place to address human rights-related barriers to malaria accessing services.

Malaria Epidemiology

(a) General

WHO estimates that 41.2 million people living in Kenya were at risk for malaria in 2016 (WHO, 2017b). Although national malaria parasite prevalence decreased between 2010 and 2015, there were 8.3 million cases presumed and confirmed cases of malaria in Kenya in 2016, an increase from 7.7 million in 2015 (WHO, 2017b). Based on routine health data, malaria accounted for 19% of incidence of disease in health facilities in 2017 (Kenya National Bureau of Statistics, 2018).

(b) Key and Vulnerable Populations

Limited data are available regarding malaria among high risk groups and underserved populations as defined by the Global Fund in Kenya. In 2013, malaria was the cause of an estimated 4% of deaths among children under five in Kenya (WHO, 2015). The 2015 Kenya Malaria Indicator Survey reports a malaria parasite prevalence rate of 8% among children age 6 months-14 years old with the highest prevalence among children 10-14 years at 11% (National Malaria Control Program, 2015). In the endemic area near Lake Victoria, malaria parasite prevalence among children in this age group decreased from 38% in 2010 to 27% in 2015; while in the Coast Endemic area it increased from 4% to 8% during the same period (National Malaria Control Program, 2015). No data could be found regarding malaria prevalence among prisoners and incarcerated populations in Kenya during the desk review. However key informants from the Kenya Prison Service in Kisumu indicated there were generally about two cases of malaria a day, even as larger outbreaks are known to occur (key informant interview 58). It was very difficult to find any information on malaria among refugees.

Protective Laws Relevant to Access Malaria Services

(a) National Strategy

The national malaria response in Kenya is led by National Malaria Control Program (NMCP) housed in the Division of Communicable Disease Prevention and Control in the Department of Preventive and Promotive Health of the Ministry of Health. With the overall vision of a malaria-free Kenya, the Kenya Malaria Strategy (KMS) 2019-2023, describes key objectives to be achieved under the guiding principle of “adherence to the principles of human rights, gender, and equity”. Objectives include “To protect 100 percent of people living in malaria risk areas through access to appropriate malaria preventive interventions by 2023”, “To strengthen malaria surveillance and use of information to improve decision making for program performance” and “To provide leadership and management for optimal implementation of malaria interventions at all levels, for the achievement of all objectives by 2023” (National Malaria Control Program, 2019). The KMS defines key populations as those with higher geographic risk living in malaria endemic regions. Malaria is endemic to western Kenya near Lake Victoria, including Kisumu, and coastal areas including Mombasa.

(b) Laws

There are two laws that are relevant to malaria prevention and control in Kenya: The Public Health Act, 1986 (National Council for Law Reporting, 2012b) and the Malaria Prevention Act, 1983 (National Council for Law Reporting, 2012a).

Section 168A of the Public Health Act, 1986, gives every Municipal Council the authority (with the approval of the Minister of Health), to make bylaws for preventing and abating conditions permitting or favoring the breeding of mosquitoes and flies and, generally, for the prevention of malaria and other insect-borne diseases. Sections 136-143 of the Public Health Act, 1986, declare all breeding places of mosquitoes such as stagnant water, sewage, rubbish, etc. to be a nuisance. Fines may be imposed on property owners where mosquito breeding is likely or already occurring. These provisions can be strong measures to promote an environment that is not conducive to mosquito breeding, but it is also important to consider if, as with HIV, use of criminal law in this context might perpetuate discrimination (e.g. on the basis of poverty) or extortion. While there are punitive aspects of the law, there is no evidence of implementation of fines in this context.

Sections 3, 5, 6, 7 and 13 of the Malaria Prevention Act, 1983, set forth a range of malaria prevention strategies such as: formation and maintenance of drainage systems (Section 3); ensuring the flow of water without any obstruction (Sections 5, 6); construction of drains (Section 7); and penalties of 1000 shillings for people not carrying out their obligations under this act (Section 13). As prevention of mosquito breeding has been shown to be an effective strategy to prevent malaria, these are protective laws which aim to prevent and deter people from engaging in unhealthy practices. While there are punitive aspects of the law, there is no

evidence of implementation of fines in this context; as above, the appropriateness of the use of criminal law in this context is worthy of consideration.

Due to the nature of malaria transmission, these laws focus on environmental considerations to reduce breeding grounds for mosquitos. Nevertheless, broader health laws and policies may also be considered protective provisions in the context of malaria, given that malaria services are a component of primary healthcare. Details regarding the above-referenced laws relevant to malaria that apply broadly across key and vulnerable populations are also included in Annex 11.

Human rights-related barriers to malaria services

This section of the report focuses on specific barriers experienced by relevant vulnerable populations in accessing malaria services. Broadly these barriers include: poverty and economic and social inequality, gender inequality, discriminatory barriers to accessing primary healthcare and malaria-specific services, as well as barriers concerning insufficient availability and accessibility of services and government and health service coordination. Each subsection below includes a descriptive analysis of the nature and direct and indirect impacts of barriers in the context of malaria.

Of particular importance in the context of malaria is that community mobilization interventions are severely under-funded due to difficulties in measuring results (key informant interview 63). This has an impact across all of the other types of barriers and on any programs designed to address these barriers.

(a) Underlying Poverty and Economic Inequality

Poverty was reported to be a barrier in accessing health services for malaria. Key informants from Nairobi and rural areas indicated that even though malaria diagnosis and treatment are free, the cost of transportation to a health facility is a significant barrier in accessing services (key informant interviews 70, 72). In addition, malaria reportedly exacerbates poverty due to the loss of productivity (key informant interviews 60, 61). While the government offers free malaria treatment in all government facilities, in some areas there are only private and faith-based-managed health facilities which charge user fees. This results in delayed care-seeking behavior for the non-insured population or non-completion of treatment dose (key informant 63).

Rural populations and informal settlements are most affected by underlying poverty as a barrier to access care (key informant interview 63). For some particularly marginalized populations, such as certain ethnic and linguistic minorities (Ogiek, Sengue, Endoroi, Boni, Maasai, Samburu) and forest dwellers (Mt Elgon, Boni forest, Mau forest), they can face a tough choice between buying food or paying for transportation to seek malaria diagnosis and treatment with their limited resources (key informant interview 24).

(b) Gender Inequalities

In-country interviews highlighted gender-related disparities in malaria prevention and treatment. Key informants from NGOs in Mombasa and Nairobi indicated that women do not always have decision-making power regarding their health seeking behavior (key informant interviews 62, 72). Similarly, mothers of children under five years old in Kisumu reported many men are “idle” in regard to health management and household expenditures often prioritizing other expenses over healthcare (focus group discussion 7).

Additional disparities were noted by a key informant in Mombasa who indicated that children under five years of age and pregnant women are the only people given nets for free at health facilities. They further noted pregnant women often sleep alone, so men sleep without a net. In some instances, pregnant women reportedly give the net to the male head of household to protect their health as the primary breadwinner leaving the pregnant women exposed (key informant interview 61).

Key informants from Nairobi and Kisumu indicated there is a low level of health seeking behavior among men, and a need to tailor malaria programs toward men in private and informal sectors as well as on the household level, perhaps through the use of community health workers (key informant interviews 63, 64).

Gender influences exposure to malaria: women are at increased risk as they are often more likely to collect water early in the morning or cook outside in the evening; however men can also face increased risk where they are more likely to work in the fields in the evening, to be involved in fishing activities and to work as night watchmen (Malaria Control Unit - Ministry of Health, 2015). There is relatively little data available on gender-specific malaria risks in Kenya, which impedes gender-responsive interventions such as targeting prevention messages to each gender based on actual risk behaviors.

While community health volunteers have been widely used to carry out community level malaria work, it is important to note that the sex of the volunteer matters with regard to who they can best reach within a household. Female community health volunteers are more likely to connect with women in a household, while male community health volunteers are more likely to talk with the men. Given men’s role in household decision-making around malaria, this can constitute a barrier in areas where community health volunteers are predominantly female.

A key informant from Nairobi indicated gender-disaggregated data are collected at a community level, but disaggregation is lost when data are reported to higher levels, which obscures gender disparities in national level data (key informant interview 63).

(c) Discriminatory Barriers to Accessing Primary Healthcare and Malaria-specific Services

Unlike TB and HIV, stigma and discrimination associated with the spread of malaria infection are not among the major barriers to access to malaria services in Kenya. Furthermore, malaria services are provided through primary health care services, so there is no need for people to attend an HIV or TB clinic to access services, further limiting the potential for stigma and discrimination even among people living with HIV or TB.

However, some interventions may not be in line with cultural norms, resulting in some treatment and prevention options being stigmatized by communities and low uptake. For example, a key informant in Nairobi explained that some people along the coast believe sleeping under a rectangular net will cause hallucinations because it is in the shape of a coffin (key informant interview 60). Key informants in Kisumu and Nairobi reported net-related stigma associated with bedbugs: in both counties it was reported that people believe the nets are a breeding ground for bedbugs (key informant interviews 60, 64, 72).

Misconceptions about medications resulting in stigma were also reported during in-country data collection. A key informant in Nairobi explained that in some areas women can be suspicious of intermittent preventative treatment in pregnancy (IPTp), so uptake is lower. In Migori and Homa Bay, malaria is thought by some people to be witchcraft, so people reportedly hide at home rather than seeking treatment to prevent others from finding out (key informant interview 59). A key informant in Mombasa also indicated that rumors of medications being laced with birth control act as a barrier to uptake of malaria services. In addition, some clients at the health facility reportedly associate blood draws with devil worship as they are unaware of what is done with the blood used for testing (key informant interview 61).

Disabled populations may be excluded from malaria response efforts due to the associated stigma. There are approximately 4.5 million people with disabilities in Kenya, almost 3 million of whom live in rural areas where service coverage can be low (Amref, 2017). A key informant in Mombasa indicated people living with disabilities and the elderly are excluded from net distributions at health facilities (key informant interview 61). However, a key informant from the government in Nairobi refuted this saying that people living with disabilities are not excluded from household net distribution (key informant interview 70). Other barriers to accessing malaria programs that are reported to be disproportionately experienced by people with disabilities include: exclusion from social protection programs, delays in registration for social protection programs, lack of social and behavior change communication materials in formats that are accessible for people with visual or auditory impairment, and health facilities that are physically inaccessible (key informant interview 63).

One key informant from the government in Nairobi reported there was no stigma associated with malaria (key informant interview 70).

Although in many cases, refugees face additional barriers accessing health services when compared with other populations, with regard to malaria a tension arises due to the availability

within the camps of commodities such as the provision of social and behavior change communication interventions, bednets, and IPTp intervention which are not available within the host communities as they are not recommended interventions within the host communities' environment (key informant interview 63). For internally displaced persons, barriers to the accessibility of health facilities within host communities were also reported (key informant interview 63).

(d) Availability and Accessibility of Malaria Services

Many of the barriers that affect access to malaria services are the same as those affecting access to primary health care services in general. The physical location of health facilities in relation to service users and availability of transportation influence where, when and what sort of treatment for malaria is sought. A key informant from the government in Nairobi indicated that those living in areas without road access face significant challenges in accessing services (key informant interview 70). Coverage of malaria services in rural areas is lower than in urban areas (Amref, 2017), (key informant interview 60). Frequent drug and commodity stock outs, including malaria tests, were noted by key informants in Nairobi and Kisumu (key informant interviews 59, 60, 72, focus group discussion 7). Additionally, there are administrative and logistical barriers to drug distribution at the county level which result in drug shortages (key informant interviews 59, 60, 72). Specifically, key informants indicated that some counties are not able to access health commodities because they are in debt with the Kenya Medical Supplies Authority (KEMSA) (key informant interviews 60, 72).

A key informant in Nairobi explained that, in 2017, heavy rain in Marsabit and Turkana resulted in an upsurge in malaria. At this time, it became clear there was a lack of strategy for response in non-endemic areas as counties were unable to obtain the drugs and commodities needed (key informant interview 59).

In addition to the issues of availability and accessibility, the issue of access to quality health services was also reported. Mothers of children under five years old in Kisumu reported that due to frequent drug stock outs and inconsistent treatment methods they feel as if they are given whatever medications are available at a health facility rather than what is medically appropriate (focus group discussion 7). A key informant in Nairobi indicated knowledge gaps among some senior health care workers who prefer to use older, less effective treatment regimens. Additionally, among those treating pregnant women, IPTp is not optimally administered as the focus is on the number of doses administered rather than timing of doses to optimize effectiveness (key informant interview 60). In Kitui, a key informant reported that herbal treatments for malaria are used because there are no malaria drugs available at health facilities or they are too expensive (key informant interview 76).

In addition, key informants in Nairobi and Mombasa both indicated health care workers may be selling nets outside of the health facility resulting in fewer nets for distribution through official programs (key informant interviews 60, 61).

There was a court ruling in May 2019 which barred non-laboratory staff, which includes community health workers, from conducting tests at both the health facilities and the community level. This impedes the administration of rapid diagnostic testing and provision of treatment for uncomplicated malaria in communities (*Association of Kenya Medical Laboratory Scientific Officers v Ministry of Health & Attorney General*, 2019).

(e) Barriers for Vulnerable Populations

(i) Mobile populations

The term “mobile populations” encompasses an enormous range of different communities including refugees, migrant laborers and pastoralists, to name just a few. Very little data is available on the individual communities that fall within this umbrella term, suggesting that this is an area where additional research is required.

Even as UNICEF does some procurement relating to malaria for the refugee camps, access to malaria prevention diagnosis and treatment within refugee camps remains sub-optimal (key informant interview 59). Other mobile populations, such as truck drivers, who sleep in or under their vehicles without access to mosquito nets, are also at high risk (International Organization for Migration & Great Lakes Initiative on HIV/AIDS, 2006).

Distance to services is an issue that particularly affects mobile populations who often experience an upsurge of seasonal malaria and can face challenges accessing health services due to being far away. This can delay health-seeking, resulting in increased severity of the disease or death (key informant interview 63).

(ii) Prisoners

Lack of availability of malaria prevention and treatment services was the most significant barrier identified by key informants for prisoners in Kenya. A key informant explained malaria is not considered part of routine health services, even in high transmission areas, and instead is treated as an acute illness (key informant interview 65). Key informants indicated there are no mosquito nets in men’s prisons, as there are no beds (key informant interview 58), and they are seen as a suicide or security risk (key informant interviews 58, 60, 70). In women’s prisons, mothers of children under five years of age can use nets that are provided by the family. It was also reported that women received nets for “good behavior” (key informant interview 58). Rapid diagnostic tests for malaria were reportedly not available in Nairobi prisons as malaria is not endemic in Nairobi; however, many of the inmates come from endemic areas (key informant interview 31). One key informant noted that drugs for the treatment for malaria have not been available for a long time in the health services that prisons use, and staff and surrounding communities self-medicate without a diagnosis (key informant interview 40). There were reports about the use of indoor residual spraying (IRS) in prisons with one key informant stating that it is

not used because the chemicals could pose a risk to prisoners (key informant interview 60) and another key informant stating that it is used, albeit inconsistently in “strong” counties (key informant interview 40).

There are administrative challenges reported in the provision of health services in prisons as it is not always clear where responsibility lies- the prisons are managed at the national level through the Ministry of Interior, whereas health is devolved to county level through the Ministry of Health. It is therefore unclear to many involved who is responsible for the provision of health services to prisoners and incarcerated populations. In addition, a key informant explained it is unclear where prisoners are included in the implementation of universal health coverage (key informant interview 40).

Existing Programs to Address Human Rights-related Barriers to Malaria Services

(a) Introduction

Substantial efforts have been made to tackle malaria in Kenya. Malaria treatment and prevention interventions are typically biomedical in nature, with the distribution of bed-nets, access to IPTp, treatment with Artemisinin-based combination therapies and, to a lesser extent, indoor residual spraying (IRS) being the most common interventions. In addition, the media has been used to disseminate messages on malaria prevention and the importance of care-seeking. This report focuses on programs that specifically address human rights-related barriers to malaria services rather than the entire malaria response. In the context, relatively few programs with a human rights focus have been identified to date.

(b) Human Rights and Gender Assessments

No evidence was found of implementation of the Malaria Matchbox Tool in Kenya, but a few other relevant assessments have been carried out over the past few years.

In 2015, the MEASURE Evaluation PIMA Project in Kenya, in coordination with the MOH, conducted a malaria and gender review. Using data gathered from records, data reviews and in-country interviews, the disparities that exist in awareness, prevention, and access to treatment were evaluated. Findings were used to inform the revised NMS strategy and monitoring and evaluation plan (Malaria Control Unit - Ministry of Health, 2015).

The Kenya Malaria Indicator Survey (KMIS) 2015, implemented by the NMCP of the MOH and the Bureau of Statistics also provides information about malaria, some of which is disaggregated by sex. Information about the composition of households, use of mosquito nets by people in the household, access to LLINs by women, and utilization of antenatal care is

particularly useful to determine the performance of interventions with regard to gender (Malaria Control Unit - Ministry of Health, 2015). Sex-disaggregated data are also collected through the Qualitative Study on Barriers to Net Use among Most at Risk Populations and the Evaluation of the Long-Lasting Insecticide Treated Net Distribution Campaign (Malaria Control Unit - Ministry of Health, 2015).

During the period June-December 2018, there was a national Malaria Program Review and subsequently the development of the Kenya Malaria Strategy 2019-2023. CSO representatives were supported to attend and contribute their malaria experiences to the Malaria Program Review as well as the Strategic Plan development. Also, in 2018, a community, rights and gender assessment was carried out by the Kenya NGO Alliance Against Malaria (KENAAM), incorporated into the Malaria Program Review. The recommendations proposed from the two reviews and strategic planning process focused on the engagement of communities in malaria control interventions taking the context of gender, inequalities, and disabilities as drivers of the next strategic plan (KeNAAM, 2018). Specific recommendations included: capacity-building of communities to participate in design, implementation and monitoring of malaria plans and interventions; tailoring interventions to specific populations rather than channels of delivery for programs; ensuring specific attention to reaching those who might be “left behind”; exploring opportunities to support host communities to implement pre-elimination interventions; and advocacy for incorporation of gender disaggregated by sex/gender into data summary tools.

(c) Meaningful Participation of Affected Populations

The Strategy for Community Health provides a framework for community engagement in health. KeNAAM coordinates the affiliated civil society and private sector organizations working on malaria who participate in the development of strategies, plans and advocacy work as well as the county-level roll out of the Strategy for Community Health (Amref, 2017).

In 2018, KENAAM worked to ensure the participation of CSOs in the national Malaria Program Review that was designed to feed into the Kenya Malaria Strategic Plan 2019-23. This included providing financial support as well as technical support on messaging around community, rights and gender in the context of malaria. The adoption of human rights and gender as guiding principles in the strategic plan was at least partly the result of the CSOs’ sustained engagement throughout this process (KeNAAM, 2018). The importance of including CSO experiences in malaria programming in policy discussions seems to be increasingly recognized by the National Malaria Control Program.

During these planning processes, CSOs were also supported to participate in the Malaria Interagency Coordination Committee (MICC) and Technical Working Group (TWG), which resulted in the incorporation of community experiences in the policy discourse (KeNAAM, 2018).

The NGO SCOPE reported working to mobilize communities in Kilifi and Kwale to access services and also working with duty bearers to help them understand communities and how best to align with communities. Another NGO in Mombasa, PUMMA, also reported carrying out work with duty-bearers to help them understand communities' needs and how best to align with communities, as well as work to embed human rights in existing systems so as to reduce discrimination but no further details of this work, including geographic scope were available.

(d) Strengthening of Community Systems for Participation in Malaria Programs

Community systems are being used in various different ways with regard to malaria interventions. Increased attention has recently been given to rural populations' participation in malaria programs to address the fact that these communities often have low coverage of malaria services as compared to urban populations. Community health actions have been deployed by government and a range of NGOs, including preventive and case management services to include hard-to-reach populations (Amref, 2017). Efforts have been carried out to enhance the availability and capacity of facilities nationwide, in accordance with the Constituencies Development Fund (CDF) and Economic Stimulus Package of 2010, although the extent of ongoing work in these areas could not be ascertained (Waters et al., 2013).

One implementer noted that the Global Fund, through the Community, Rights and Gender Technical Assistance Program, is the main partner on meaningful participation and human rights, with advocacy costs built in alongside implementation budgets in the current grant.

(i) Community case management of malaria and community health volunteers

Overall population coverage of community case management of malaria is estimated to be 30% of the lake endemic region, while the coast endemic region is not covered (key informant interview 60).

One critical intervention is the use of community health volunteers to deliver malaria-related services, including community case management of malaria (CCMM) and the provision of information about malaria, particularly to high-risk populations with historically low intervention uptake (PMI, 2019). For example, Amref is the principal recipient of a grant from the Global Fund to address community case management of malaria in ten high burden counties (Busia, Bungoma, Kakamega, Vihiga, Kisumu, Homabay, Migori and Siaya). This involves a network of community health volunteers who regularly visit households to conduct testing, treatment and referral of severe cases to health facilities. Plans are included under the current Global Fund grant to scale-up CCMM using community health workers from the current 30% population coverage by 735 community health units to 50% population coverage by 940 community units in the lake endemic region (Division of Malaria Control Ministry of Public Health and Sanitation, 2009). This will involve training of 7,350 community health volunteers across the ten counties, which constitutes an important entry point for including human rights and legal literacy training to this cadres of community workers. In addition, to further enhance community participation,

malaria social and behavior change communication activities will be brought to the community level through home visits, health dialogue and action days, and sports and outreach events.

Evaluations have found that well-trained community health volunteers can increase access to prompt and effective malaria treatment, especially among the poorest households, improve pregnant women's uptake of ANC services to access IPTp, improve treatment-seeking behavior, reduce the burden of uncomplicated malaria cases on health facilities, reduce the costs of malaria treatment and, in some cases, reduce the number of malaria cases in the community (Siekman et al., 2013), (USAID, 2018), (Amref, 2013), (Amref, 2017). While most of this work has been carried out in the malaria endemic areas around Lake Victoria, some of these interventions have also taken place in coastal areas. All of these activities could also incorporate legal literacy work.

Reported advantages of using community health volunteers for CCMM include accessibility of community health volunteers for advice or treatment for child fever, convenience of home visits, avoiding long wait times at health facilities efficient referrals to health facilities when needed, and the provision of health education by community health volunteers (Siekman et al., 2013), (Amref, 2018), (Owek, Oluoch, Wachira, Estambale, & Afrane, 2017). Reported challenges included some clinicians doubting community health workers' capacity to correctly dispense drugs, breeches of confidentiality by community health workers, mistrust of community health workers and shortages of drugs and basic supplies (Boakye, Owek, Oluoch, Wachira, & Afrane, 2018; Owek et al., 2017).

As one example of work in this area, under the Maternal and Child Survival Program, training of community health volunteers started in Bungoma and has now been scaled up to 30 malaria-endemic sub-counties (USAID, 2018). In addition, PS Kenya is training community health volunteers to test and treat malaria in Busia and Nairobi counties (key informant interview 72).

Key to understanding the increase in CCMM is the advocacy work that took place to deregulate artemisinin-based combination therapy (ACT), which had previously required a prescription, so that it could be made available over the counter. A wide range of organizations, including KeNAAM, was involved in this work that has led to a substantial increase in availability of ACT, particularly in rural/hard-to-reach areas, and allowed for the treatment of simple malaria by community health workers.

The impact of, and response to, the court ruling in May 2019 which barred non-laboratory staff from conducting tests at both the health facilities and the community level is important to understand in this context. The Ministry of Health, through its legal department, is currently pursuing the matter to comply with the court ruling which directed public engagement in development of the task-sharing policy. It will be important that the implications of this court ruling be better understood as national plans are developed to ensure both that plans comply with the law and that they make best possible use of the task sharing policy. Amref, together with the Division of National Malaria Program, has engaged relevant stakeholders – Kenya Medical Laboratory Technicians and Technologists Board (KMLTTB), Pharmacy and Poisons Board (PPB), Association of Kenya Medical Laboratory Scientific Officers (AKMLSO), Kenya

Medical Training College (KMTTC) and Kenya Medical Research Institute (KEMRI) to strengthen structures for implementation of community case management of malaria. From these engagements, AKMLSO supports task-sharing with recommendations to strengthen structures for quality assurance and oversight. Amref is spearheading the revision of guidelines for community case management of malaria, training curriculum for community case management of malaria, framework for malaria rapid diagnostic tests and training manuals for community case management of malaria, all of which could usefully incorporate legal literacy and attention to human and patients' rights.

In an effort to formalize the structures around community health volunteers, several civil society organizations have been carrying out advocacy for county governments to start paying community health volunteers and at least five counties have already assumed these stipend costs. They are currently doing this work in Siaya, Homa Bay and Migori. Ultimately, national-level legislation may be needed to support this, but some counties are moving forward with it nonetheless. KeNAAM is also training civil society to access data and use it to try to influence county-level malaria budgets to include attention to rights and gender. Using concepts of social accountability, this includes resource tracking and community scorecards (key informant interview 63). This is being implemented in six counties in the coastal region (Kwale, Kilifi, Lamu, Tana River, Taita Taveta and Mombasa); two workshops have been held, totaling 40 participants (KeNAAM, 2019). SCOPE has also carried out work in Kilifi and Kwale to inform communities about budget cycles so they are aware how to engage county governments to articulate their priorities.

(ii) Communication

Alongside LLIN distribution, investments in communications have been successful at raising awareness about malaria, especially amongst vulnerable groups. Sources such as radio, television, and relevant print media that are culturally appropriate have been the most effective because they are commonly accessed by the general population (Amref, 2017). The Malaria Communication Strategy 2016-2021 provides a framework within which this work can be implemented (National Malaria Control Program - Ministry of Health, 2016). However, there is still a need to enhance community engagement to ensure that the messages distributed are understood by intended audiences and put into practice, particularly in hard-to-reach communities who might receive fewer malaria-related interventions.

One example of community-based communications work that might complement the above-mentioned large-scale effort is an organization working in Kisumu that has carried out work with village elders by organizing *barazas* to help educate them on where mosquitoes breed, how to prevent malaria, and how to recognize symptoms. By reaching community leaders it is hoped that information and knowledge can be further disseminated within communities (key informant interview 62).

(iii) Malaria interventions in schools

A range of CSOs have implemented malaria-related interventions within schools with a view to educating children about malaria and creating champions to spread messages to help with prevention and/or eradication (key informant interviews 62, 63, 72). Although the content of these interventions, including the degree to which they are sensitive to human rights and gender concerns, is unclear, they all aim to mobilize children to be active participants in the community malaria response. Under the current Global Fund grant, 22,636 pupils from 1,279 schools have been engaged as community-level agents of change, providing another entry point for integrating human rights and legal literacy content in future trainings.

(e) Addressing Gender-related Vulnerabilities and Barriers

Many malaria prevention strategies focus on malaria prevention among pregnant women. Specific to each malaria epidemiologic risk zone, the national package of ANC services includes both malaria prevention and treatment interventions. All women attending ANC are screened for anemia and all pregnant women with potential signs/symptoms of malaria should be tested and, if appropriate, treated. In the 14 malaria endemic counties, women receive sulfadoxine-pyrimethamine (SP) for Intermittent Preventive Treatment in pregnancy (IPTp) at ANC (ideally at least three doses), and free ITNs and prevention information are provided in ANC in 36 counties (Division of Malaria Control Ministry of Public Health and Sanitation, 2009).

In the malaria endemic counties in western Kenya and on the coast, coverage of at least three doses remains low at 38%, and little attention is given to the timing of these doses (PSI-Kenya, 2019). A range of organizations have implemented interventions to help address this shortcoming through increased early uptake of ANC services and stimulating demand for IPTp at these services, for example through the use of community health volunteers (USAID, 2018).

The PMI plans to support scale-up of interventions targeting pregnant women in eight endemic counties (Bungoma, Busia, Homa Bay, Kakamega, Kisumu, Migori, Siaya, and Vihiga) using Financial Year 2019 funding with a view to reaching 50,000 pregnant women to encourage early ANC attendance and receipt of appropriate malaria services. This will target about 300 health facilities with ANC services and an estimated 600 health workers and 3,000 community health volunteers (PMI, 2019).

Women and children under five have been the target of most programming, specifically the distribution of bednets free of charge in high transmission and hard-to-reach areas through outreach visits. For example, Population Services Kenya regularly distribute on average 2.4 million bednets per year targeting these populations. In addition, in collaboration with the PMI, they distributed nearly 3.8 million bednets in five malaria endemic counties in Western and Nyanza to cover approximately 7.6 million individuals in 2018 (PMI, 2019).

Other strategies to include gender perspectives and integrate responsive policies have been adopted by the National Malaria Control Program and Amref which draw upon surveys such as the Kenya Malaria Indicator Survey. These efforts are not solely focused on targeting pregnant women and children but also engaging men to combat harmful gender norms.

(f) Improving Access to Services for Refugees and Others Affected by Emergencies

Efforts to include refugees in malaria prevention and treatment services have been spearheaded by UNHCR but are otherwise limited. UNHCR is responsible for health and welfare in four camps in Kenya, and conducts surveillance, advocacy, communication, social mobilization, and case management. Since 2008, PMI has supported the national indoor residual spraying program in Kenya. PMI has partnered with UNHCR to distribute insecticides that are past their expiration date to refugee camps, rather than destroy or return the product. With one such donation, in June of 2014, 70 trained operators were able to spray 34,000 structures (including 27 schools in the surrounding community) in Kakuma Refugee Camp and protect 143,000 people (PMI, 2014). Amref has also been working with the UNHCR to distribute bednets in refugee camps, although the impact and timeframe of this work was not specified.

(g) Malaria in People Living with HIV

An excellent example of integration of services across disease areas, the Government of Kenya provides access to LLINs and cotrimoxazole preventive therapy for free as part of the HIV Basic Care Package, although it does not isolate a specific human rights-based approach (PSI-Kenya, 2019).

(h) Improved Services in Prison and Pre-Trial Detention

There are approximately 55,000 people in prison and pretrial detention. They live in cramped conditions often with limited access to health services, including for malaria. The Ministry of Interior is responsible for case management and advocacy, communication, and social mobilization, while the National Malaria Control Program provides free medicines and indoor residual spraying (Amref, 2017). The National Malaria Strategy 2009-2017 indicates that prisons are included in indoor residual spraying campaigns and participate in performance monitoring, diagnosis, and treatment efforts. The extent to which these programs have been operationalized or are successful is unclear, but key informants suggested that this work is not prioritized, perhaps because of a perceived lack of clarity at the operational level in the division of responsibility between the Ministry of Health and the Ministry of the Interior (key informant interviews 40, 65). Both PUMMA and the Ministry of Health have done some work to install

malaria nets in windows in prisons, but coverage remains very low. Participants also reported shortages of malaria diagnostics and treatment in non-endemic areas, which was seen as a gap given high rates of prisoner transfers from malaria-endemic areas (key informant interview 31). No additional information was found with regard to malaria services in prisons and pretrial detention.

9. Investments in HIV, TB and Malaria Programs (2017)

[to be developed]

Major funders and allocated amounts for reduction of human rights barriers to HIV services in 2017 were as follows:

FUNDING SOURCE	2017 ALLOCATIONS
UNAIDS	
USAID	
Global Fund	
UNFPA	
OSIEA	
PMI	
CDC	
DOD	
Government	
Total	

Although several funders stated that they were unable to provide exact figures for the amounts allocated to each program area, the assessment team calculated the likely split between program areas by acquiring expenditure data from the funded organizations and matching these to activities under each program area. This gave the following split of funding across program areas for each disease as summarized below.

HIV 2017

HIV Human Rights Barriers Program Area	2017 (EXPENDITURES IN USD)
PA 1 Stigma and discrimination reduction for key populations	
PA 2 Training for health care workers (HCW) on human rights and medical ethics related to HIV	
PA 3 Sensitization of law-makers and law enforcement agents	
PA 4 Legal literacy (“know your rights”)	
PA 5 HIV-related legal services	
PA 6 Monitoring and reforming laws, regulations and policies relating to HIV	
PA 7 Reducing discrimination against women in the context of HIV	
PA 8 Relevant activities but which cannot be classified elsewhere	
TOTAL	

TB 2017

Budget allocations =

Money Disbursed =

Expenditures = NIL – This is explained by lack of available data accounting for expenditures for the disbursed money.

Tuberculosis Human Rights Barriers Program Area	2017 (EXPENDITURES IN USD)
TB1-Reducing stigma and discrimination	-
TB2-Addressing gender related risks to TB and barriers to services	-
TB3-TB-related legal service	-
TB4-Monitoring and reforming laws, regulations and policies that impede TB services	-
TB5-Knowing your TB-related rights	-
TB6-Sensitization of law-makers, judicial officials and law enforcement agents	-
TB7-Training of health care providers on human rights and ethics related to TB	-
TB8 - Ensuring confidentiality and privacy	-
TB9-Mobilizing and empowering groups of people affected by TB and community groups	-
TB10-Programs in prisons and other closed settings	-
TOTAL	-

MALARIA 2017

Budget allocations =

Money Disbursed =

Expenditures =

Malaria Human Rights Barriers Program Area	2017 (EXPENDITURES IN USD)
MA 1 Programs to monitor and reform laws, regulations and policies relating to malaria prevention and control	-
MA2 Meaningful participation of high-risk and underserved populations	-
MA3 Strengthening of community systems for participation in malaria programs	
MA 4 Addressing barriers in ITN use	
MA 5 Addressing barriers to indoor residual spraying (IRS)	
MA 6 Addressing barriers to IPTp (Chemoprevention)	
MA 7 Addressing barriers through IEC/SBCC	
PA 8 Addressing barriers to appropriate case management	
TOTAL	

The data underlying all of these tables is provided in a separate document.

10. Comprehensive Programs to Remove Human Rights-Related Barriers to HIV, TB and Malaria Services

Introduction

This section describes, according to the key program areas that are the focus of this assessment, a comprehensive national response to human rights-related barriers to HIV, TB and malaria services. HIV and TB are jointly addressed to avoid unnecessary repetition due to the substantial overlap in programming to address human rights barriers to accessing HIV and TB services. Where an activity is relevant to only HIV or TB, this is noted. Malaria is then addressed separately.

In each case, prior to an explanation of the proposed interventions, a table is provided which is organized by the primary program area where work is occurring. It is good to note that there are programs which can be scaled up in most of the program areas.

The table is structured as follows:

- The first column of the table notes the type of activity, and examples of what such activity could look like drawing on the information received through the assessment.
- The second column of the table notes the level of the intervention required (e.g. national, health facility etc.).
- The third column of the table notes the recommended scale of activity.
- The fourth column notes the type of institution most likely to take the lead in this work. Consultation will seek to identify specific organizations with the capacity, mandate and intent to implement such activities.
- The final, fifth column notes the proposed timeframe for implementation.

While efforts have been made to ensure that the proposed comprehensive response to human rights-related barriers to HIV, TB and malaria services address the main human rights barriers to accessing services that have been identified, some of the barriers require intervention beyond the scope of the human rights program areas and funding available for human rights and are therefore not included.

(a) Overarching Contextual Issues

The biggest contextual issue in Kenya is the recent devolution of the health function to county level. County-level capacity to create and implement policies and programs relating to HIV, TB and malaria is mixed, as is their ability and willingness to prioritize and budget for these activities. While moving decision-making around health to a more local level makes sense, there is a learning curve and all stakeholders require additional support through this process. Furthermore, where advocacy used to be centralized at the national level, it is now critical that civil society can

also engage in the processes of policy-making, program design and monitoring of evaluation at the county level. Ultimately, devolution of the health function necessitates concomitant decentralization of the program activities described herein, with evident implications for the timeframe and budget for this work.

The HIV, TB and malaria landscape in Kenya is incredibly complex. A multitude of different population groups are affected, many different stakeholders are required for comprehensive action, and all programming must be tailored to the specificity of each location. Central to all of this is ensuring that the right mix of institutions is involved at every level. This will require broad-based partnerships of people who may never have previously worked together as well as a willingness to share resources to ensure that the most appropriate institution for each task can be funded to take it on. The administrative burden of this is substantial. This analysis has focused on the roles of civil society organizations and governments but there are also, obviously, key roles to be played by intergovernmental organizations and other development partners whose comparative advantages should be analyzed in the context of the different interventions being proposed.

For practical reasons, the comprehensive package of interventions proposed is divided into the different program areas delineated by the Global Fund. However, these should not be seen as separate programs of work: these program areas are designed to be complementary and mutually reinforcing. Many human rights barriers to accessing services are driven by intersectional inequalities, with intervention required across many different spheres in order to overcome them. This necessitates a collaborative, multisectoral response.

(b) Overarching Principles

Four overarching principles are critical to keep in mind for the entire proposed comprehensive response to human rights-related barriers to HIV, TB and malaria services:

1. Affected populations – people living with HIV, people affected by TB or malaria, and key and vulnerable populations – should be the driving force behind this work. That means that they should be appropriately funded and supported to lead and participate in all of these activities.
2. Human rights programming is a technical area that requires a different skill set than biomedical or public health responses to HIV, TB and malaria. It is highly likely, therefore, that any funds allocated to this set of interventions will have to be sub-granted to organizations of affected populations (as noted above) and those with human rights expertise in order to ensure quality implementation.
3. The proposed comprehensive response includes a wide range of capacity-building activities. However, as noted above, training is necessary but on its own insufficient to effect the desired scale of change. Support to follow-up activities that allow multi-stakeholder collaborations to implement their newfound knowledge over time and at scale should be prioritized to maximize the impact of these capacity-building efforts

4. It is crucial that process and interim outcome evaluation be built into these different activities to identify potential shortcomings and allow for course correction, if necessary, during the grant period. For example, all training should incorporate evaluation of the training (immediately on completion), evaluation of short-term impact through follow-up with participants after one year to see what they have done differently as a result of the training, and curriculum review after three years of implementation. There are resource implications attached to this, but it is an investment that will help direct funding most efficiently moving forward.

Optimal Program Mix for a Comprehensive Response to Human Rights-related Barriers to HIV, TB and Malaria Services

The tables below propose an optimal program mix for a comprehensive response to human rights-related barriers to HIV, TB and malaria services. The scale and timing/frequency of activities proposed is based on discussions with in-country stakeholders, taking into account existing capacity both for implementation of activities and for carrying out capacity building that might be required to facilitate implementation. In some cases, the scale of activities being proposed is less than would be ideal, but is designed with feasibility in mind; these should be considered minimum targets.

(a) HIV and TB Programs

Activity	Level of intervention	Scale of intervention	Lead institution	Timing and frequency of activity
Stigma and discrimination reduction for key and vulnerable populations (HIV and TB)				
PLHIV Stigma Index	Community	National	CSOs	Y1, Y3, Y5
TB Stigma Assessment	Community	National	CSOs and government (NLTP)	Y1, Y3, Y5
Targeted studies on HIV/TB-related stigma and discrimination experienced by specific populations. Data on transgender populations, prisoners and migrants should be prioritized	Community	National	CSOs	Y2, Y4
Media campaigns of human rights messages related to HIV and TB: radio, social media. These should be designed and led by people living with HIV, people affected by TB and other key and vulnerable populations.	National, County: the 5 'high stigma counties'	National	CSOs, government	National level: Y2, Y4 County level: Y1, 3, 5

Activity	Level of intervention	Scale of intervention	Lead institution	Timing and frequency of activity
Sensitization and engagement of county government and other leaders (religious etc.) alongside key and vulnerable populations in nondiscrimination campaigns	County, community	Priority counties	CSOs	Meetings every 6 months for Y1-5, with support to campaigns and/or activities between meetings
Psychosocial support groups to address self-stigma (general groups for people living with HIV but also groups specific to other key and vulnerable populations including women, adolescents, transgender populations and others	Community	Priority counties	CSOs	Monthly meetings Y1-5 rolled out progressively across counties, with different population groups targeted based on size of different key populations, overall HIV/TB-related stigma.
Advocacy by affected populations to improve access to good quality services for key and vulnerable populations free from stigma and discrimination (including men who have sex with men, female sex workers, people who use drugs, transgender people, adolescents, prisoners, refugees, migrants).	National level	Priority counties	Key- and vulnerable population-led civil society organizations	Advocacy training every 6 months, with support for advocacy activities between trainings.
Incorporation of human rights messages into ongoing health interventions sensitive to the needs of people with disabilities	Community, health facility	Priority counties	CSOs, government	Y2, Y4
<p>Programs to reduce stigma and discrimination in the workplace (including informal economy):</p> <ul style="list-style-type: none"> - Sensitization of management on HIV and TB in the workplace and support to development of anti-discrimination workshop policies - Sensitization of teachers on HIV, TB, gender and human rights - Awareness raising on NHIF and SACCO - Programs to reduce TB-specific stigma and discrimination (people working 	Workplace, clusters of workplaces (e.g. schools)	Priority counties	Trade unions, CSOs, government	

Activity	Level of intervention	Scale of intervention	Lead institution	Timing and frequency of activity
<ul style="list-style-type: none"> in public transportation and in quarries) - Creation of a system of redress for cases of workplace TB-related discrimination - Awareness raising on HAT as a system for redress 				
Training for health care workers on human rights and medical ethics (HIV and TB)				
Assessment of health care worker knowledge of human rights and ethics, and client experiences of stigma, discrimination and rights violations (baseline and follow-up)	Health facility	Priority counties	CSOs	Y1, Y3, Y5
Advocacy with leadership of MOH and health training institutions for buy-in to curriculum change	MOH and health care training institutions	National	Government and CSOs	Y1
Map existing curricula and develop a standardized curriculum for pre-service training on human rights and medical ethics relating to HIV and TB	Health care training institutions	National	Government and CSOs and national learning institutions	Y1
Incorporate the pre-service training into regular health worker training and examination (at all levels)	Health care training institutions	National	Government and national learning institutions	Y2
Build capacity of health care training institution personnel to deliver the pre-service curriculum	Health care training institutions	National	Government	Y2, Y3 (refresher)
Map existing curricula and develop a standardized curriculum for in-service training on human rights and medical ethics relating to HIV and TB	Health facility & Community	National	Government and CSOs	Y1
Build capacity of government and CSOs to deliver the in-service curriculum	Community	Priority counties	CSOs	Y1

Activity	Level of intervention	Scale of intervention	Lead institution	Timing and frequency of activity
Regular in-service refresher training for all health facility staff	Health facility	Priority counties	Government and CSOs	Target 50 per county (500 total) = 125 per year for Y2-4.
Training of and ongoing support to community health volunteers, particularly for TB, with attention to appropriate gender-mix	Community	Priority counties	Government and CSOs	
Sensitization of law-makers and enforcement agents (HIV and TB)				
Advocacy with the Director of Training of the Kenya Police Service and the Commandant of the Prison Staffs Training College for curriculum change	Police Training College and Prisons Staff Training College	National	Government and CSOs	Y1 intensive
Map existing curricula and create a standardized pre-service training curriculum for law enforcement agents and prison officers on HIV, TB, human rights and the law, and key populations	Police Training College and Prisons Staff Training College	National	Government and CSOs	Y1-2
Incorporate the pre-service training into regular police and prison officer training and examination	Police Training College and Prisons Staff Training College	National	Government	Y2
Build capacity of the police and prison officer training institutes to deliver the pre-service curriculum	Police Training College and Prisons Staff Training College	National	Government and CSOs	Y2
Outreach to senior police and prison officers to help promote this training	National and county	National	Government	Y2
Incorporation of metrics around quality of service provision into performance contracts/ continuous assessment	Institutional	National	Government	Y2

Activity	Level of intervention	Scale of intervention	Lead institution	Timing and frequency of activity
Curriculum review (pre- and in-service)	Police Training College and Prisons Staff Training College	National	Government & CSOs	Y4
Faculty refresher training (after curriculum review)	Police Training College and Prisons Staff Training College	National	Government & CSOs	Y4
Map existing curricula and refine a standardized in-service refresher training for police and prison officers	Institutional	National	Government & CSOs	Y1
Regular in-service refresher training for police and prison officers	County	Priority counties	Government & CSOs	Y2-5: Quarterly training within counties (multiple trainings will be needed in each county)
Map existing curricula and create a standardized pre-service training curriculum for judges and magistrates on HIV, TB, human rights and the law, and key populations	Judiciary training institute	National	Government & CSOs	Y1
Incorporate the pre-service training into regular training for judges and magistrates	National	National	Government	Y2
Build capacity of the training institute to deliver the pre-service curriculum	Judiciary training institute	National	Government and CSOs	Y2
Map existing curricula and create a standardized in-service training curriculum for judges and magistrates on HIV, TB, human rights and the law, and key populations	Institutional	National	Government and CSOs	Y1, Y2
Build capacity of CSOs to deliver the in-service curriculum	County	Priority counties	Government and CSOs	Y2

Activity	Level of intervention	Scale of intervention	Lead institution	Timing and frequency of activity
Regular in-service training for judges and magistrates	County	Priority counties	CSOs	Y3-5: Quarterly training for 60 judicial officers held in Nairobi
Curriculum review (pre- and in-service) after 3 years	Institutional	National	Government and CSOs	Y5
Faculty refresher training (after curriculum review)	County	Priority counties	Government and CSOs	Y5
Training of senior legal researchers (currently 30) and legal researchers (currently 158) on HIV, TB and human rights	County	Priority counties	CSOs	Curriculum development: Y2 Quarterly trainings: Y3 Refresher trainings: Y5
Sensitization of court user committees on HIV, TB and human rights	Institutional	Priority counties	CSOs	Y2-5: Sensitization meetings every 6 months for each court user committee
Sensitization of parliamentarians on HIV, TB, human rights and the law - Capacity building of key and vulnerable population-led civil society networks to carry out sensitization and advocacy - Sensitization meetings	National	National	CSOs	Y1-5: Sensitization meetings every quarter for different parliamentary groups/ sub-committees (also including some repeat meetings)
Legal literacy ('know your rights') (HIV and TB)				
Expand peer human rights educator programs - Sex workers - MSM - People who use drugs - Transgender - Adolescent girls and young women - Migrant workers - Women living with HIV - TB survivors	Community	Priority counties	CSOs	Y1: Curriculum development (specific to each population) Y2-5: Deliver training to different groups of peer human rights educators, rolling out progressively.
Legal literacy trainings for key population support groups	Community	Priority counties	CSOs	Y1: Curriculum development (suggest 6 sessions for delivery 1/month) Y2-5: Deliver 6-month training to different support

Activity	Level of intervention	Scale of intervention	Lead institution	Timing and frequency of activity
				groups, rolling out progressively.
Legal literacy trainings for community, religious and county leaders	Community	Priority counties	CSOs	Y1: Curriculum development (suggest 6 sessions for delivery 1/month) Y2-5: Deliver 6-month training to different support groups, rolling out progressively.
Legal literacy trainings for teachers, parents	School/ clusters of schools	Priority counties	KENEPOTE, Teachers' service commission, PTAs	Y1: Curriculum development (suggest 6 sessions for delivery within a school term) Y2-5: Deliver training to different schools (or clusters of schools), rolling out progressively.
Capacity building of civil society, particularly key-population-led civil society, to engage in advocacy and engagement on key issues for particular affected populations in county planning, policy-making and monitoring implementation	County	Priority counties	CSOs	Y1: curriculum development Y2-5: capacity building including an initial training, ongoing technical support, and (shorter) refresher training after every year
Legal services (HIV and TB)				
Capacity-building of the National Legal Aid Service Board to promote roll out of the Legal Aid Act and policy and to take on HIV and TB-related cases	National	National	Government and CSOs	Y1-2; Y4 (refresher)
Outreach to people living with HIV, people with TB and other key and vulnerable populations to raise awareness about National Legal Aid services	Community	National	CSOs and government	Y2-Y4
Development of guidelines for justice advisory centers	National	National	Government and CSOs	Y1

Activity	Level of intervention	Scale of intervention	Lead institution	Timing and frequency of activity
Training on implementation of guidelines and HIV/TB-related human rights for justice advisory centers	County, institutional	Priority counties	CSOs	Y2-3
Assessment of justice advisory centers, including HIV/TB capacity building needs	Institutional	Priority counties	CSOs and government	Y4
Capacity building on HIV/TB for justice advisory centers	Institutional	Priority counties	CSOs	Y5
Celebration of Legal Aid Day on 24th April every year	Community	National	Government	Y1-5
Map existing training curricula on HIV and TB for peer (i.e. key and vulnerable population members) paralegals, and standardize HIV and TB training curriculum for key populations to append to existing curriculum for peer paralegals	Institutional	National	CSOs	Y1
Train trainers to implement above curriculum	Institutional	Priority counties	CSOs	Y2
Recruitment, training, supervisory support, remuneration of paralegals	Community	Priority counties	CSOs	Y2-5
Training of lawyers on HIV and TB, including specificities of the law and relevant rights	County	Priority counties	Law society and CSOs	Y2-5: Train a pool of lawyers within each county (60 new lawyers per year plus gradual refresher training for existing pool of 100 trained lawyers)
Fund to support <i>pro bono</i> lawyers' court expenses and clients' safety and security	County	Priority counties	Government and CSOs	Y1-5
Key-population-run 24/7 hotlines for members to call for advice on access to justice	County	Priority counties	CSOs	Y1-5
Capacity building of HAT employees on HIV and TB	Institutional	National	CSOs	Y1: National level Y3-5: Devolved level

Activity	Level of intervention	Scale of intervention	Lead institution	Timing and frequency of activity
Decentralization of the HAT to county level of multi-county clusters	Institutional	Clusters of counties	CSOs	Y1-2: Preparation of structures, hiring Y3: Training Y3-5: Ongoing support to HIV/TB-related cases
Community-level awareness raising about legal support structures – HAT, Court Users Committees etc. – including through accessible documents and social media	Community	Priority counties	CSOs	Y1-5
Monitoring and reforming laws, regulations, and policies (HIV and TB)				
Sensitization of county officials on the importance of civil society engagement in county planning, policy-making and monitoring implementation	County	Priority counties	Kenya School of Government, Kenya Law Reform Commission, CSOs	Y1-3: gradually rolling out across counties
Strengthening mechanisms for civil society engagement in county planning, policy-making and monitoring implementation	County	Priority counties	Government and CSOs	Y1-5: gradually rolling out across counties
Civil society community based human rights monitoring: rights-friendly health service provision, county and health facility budget allocation and expenditure, behavior of duty-bearers (police, health workers, government officials)	Community, county	National	CSOs	Y1-5
County-level human rights monitoring networks (comprising community health advocates, peer human rights educators, paralegals and <i>pro bono</i> lawyers) to consolidate and analyze HIV- and TB-related rights violations as well as outcomes of efforts to seek redress				

Activity	Level of intervention	Scale of intervention	Lead institution	Timing and frequency of activity
Support to KP TWG advocacy sub-committees (national and county levels) to ensure a full range of key population representatives can attend	National and county	National and priority counties	Government and CSOs	Y1-5
Regular fora with the Parliamentary Health Committee to keep issues relating to HIV, TB, human rights and the law on their agenda and help sensitize them to ongoing issues	National	National	Government and CSOs	Y1-5
Support to the NACC TWG on HIV, human rights and the law for capacity building and targeted research	National	National	Government	Y1-5
Innovation fund for supporting one new idea of how to effectively monitor implementation of laws/policies	Any	National	CSOs	Y1-5: One award every year
Capacity building and ongoing support for measuring/rating health services/community scorecards	County, health facility	Priority counties	CSOs	Y1-5: Two scorecards per year, with repeat scorecards after three years; Training on county budgets and social accountability for HIV and TB: once every year for all focus counties.
County level multi-stakeholder groups to promote a rights-based response to HIV and TB	County (or sub-county)	Priority counties	Government and CSOs	Y1-5: Five groups established in Y1; Five more established in Y2; ongoing support to all ten groups throughout.
Reducing discrimination against women in the context of HIV				
Ongoing technical support for gender analysis of activity plans and strengthening attention to women through all funded activities	Organizational	All principal recipients and sub-recipients of this funding	CSOs	Y1-5: Ongoing. This is a critical activity, particularly early in the grant as detailed activity plans are developed.

Activity	Level of intervention	Scale of intervention	Lead institution	Timing and frequency of activity
Incorporate legal literacy into existing programs targeting adolescent girls and young women in the context of HIV and TB	Community	Priority counties	CSOs	If programs targeting adolescent girls and young women will be included in this funding request, peer human rights education should be included.
Capacity building on gender and rights for community, religious and county leaders	Community and county	Priority counties	CSOs	Quarterly meetings at sub-county level
Psychosocial support to and legal literacy for GBV survivors and their families	Community	Priority counties	CSOs	This could be integrated with ongoing GBV projects
Capacity building on alternative dispute resolution	Community	Priority counties	CSOs	Capacity building of two civil society organizations in each priority country.
Support to alternative dispute resolution through peer mechanisms, including peer paralegals and key-population-led civil society organizations	Community	Priority counties	CSOs	This should link to the county-level network to promote access to justice described above.
Advocacy to improve legal protections for trans women, led by trans-led organizations	National, county	National	CSOs	Y1: capacity building; Y2-5: advocacy as needed; Y3, Y5: refresher training.
Reducing gender-based barriers to TB services				
Implementation of the TB/HIV gender assessment tool, including implementation of emerging recommendations	Community	High TB burden counties	Government and CSOs	Y2, Y5
Programs to address TB-related stigma and discrimination in male-dominated informal workplaces including mining, factory workers, boda boda drivers and touts etc.	Workplace	High TB burden counties	CSOs	Y1-5
Advocacy for increased recruitment of male community health volunteers in the context of TB	Community	High TB burden counties	CSOs	Y1-2

Activity	Level of intervention	Scale of intervention	Lead institution	Timing and frequency of activity
Mobilizing and empowering patient and community groups (TB)				
Training and support for human rights and legal literacy work by community health workers	Community	Priority counties	CSOs	Y1: curriculum development Y2-5: training, progressively rolled out across counties, with refresher training after 1 year
Creation and training of a network of people affected by TB	Community	National	CSOs	Y1-5
Support for human rights advocacy for social protection for people with DR-TB	Community	National	CSOs	Y1-5 as required
Programs in prisons and other closed settings (HIV and TB)				
Development of training materials on HIV, TB and human rights in prisons	National	National	CSOs	Y1
Training for prison administrators and staff on HIV/TB-related rights in prisons	Correctional facility	National	CSOs	Y1-5: gradual roll-out across the country
Psychosocial support groups to address self-stigma among prisoners with HIV or TB	Correctional facility	Priority counties	CSOs, prison staff	Y1-5: gradual roll-out across the 10 counties
Human rights training for NGOs/CBOs advocating for prisoners' rights and health	Community	Priority counties	CSOs	Y1-5: gradual roll-out across the 10 counties
Advocacy for access to ART in police cells as well as prevention of TB in these settings, identification of TB suspects and a referral system for further diagnosis and treatment	National, community, correctional facility	National, priority counties	CSOs	Y1-5 as needed
Advocacy to expand access to MAT in prisons	National, community, correctional facility	National, priority counties	CSOs	Y1-5 as needed

Activity	Level of intervention	Scale of intervention	Lead institution	Timing and frequency of activity
Advocacy for condom provision for inmates	National, community, correctional facility	National, priority counties	CSOs	Y1-5 as needed
Advocacy for support to improve prison infrastructure to avail isolation facilities for prisoners with TB, and to expand HIV and TB services within prisons	National, community, correctional facility	National, priority counties	CSOs	Y1-5 as needed
Advocacy for reform of sentencing to reduce overcrowding	National, community, correctional facility	National, priority counties		Y1-5 as needed
Advocacy for support for networking of health information systems between prisons and MOH to avoid loss to follow-up	National, county, correctional facility, health facility	National	CSOs	Y1-5 as needed
Legal literacy training for prisoners – peer human rights educators	Correctional facility	Priority counties	CSOs	Y1-5: 40 per facility
Mobile legal services in prisons in preparation for parole hearings etc.	Correctional facility	Priority counties	CSOs	Y1-5
Community psychosocial support groups for people with HIV or TB recently released from prison	Community	Priority counties	CSOs	Y1-5: gradual roll-out across the 10 counties

The proposed package of interventions is presented divided into the key program areas identified by the Global Fund, but these should not be perceived as independent strands of work. They are entirely interdependent. For example, legal literacy work can help strengthen work to monitor and reform laws, regulations and policies; sensitization of health care workers, law-makers and law enforcement agents on human rights can contribute to reduced discrimination.

The current Global Fund HIV and TB grant focuses its human rights programs in ten counties. Five of these were selected on the basis of high numbers of key populations residents who are vulnerable to human rights violations: Nairobi, Mombasa, Kwale, Kilifi and Kisumu counties. The

other five were selected because they have the lowest HIV testing, especially among men and high Stigma Index: Kitui, Mandera, Wajir, West Pokot and Garissa. These rationales remain valid. While, ideally, the proposed package of interventions would be implemented across all 47 counties, there is need to focus on these 10 counties. Within these ten counties, interventions are differently prioritized based on the selection rationale as a priority county i.e. high key population numbers or high HIV-related stigma.

Within these counties, particular attention should be given to the communities and sub-localities disproportionately affected by TB including urban informal settlements, refugee camps, prisons and mining/quarrying communities.

(i) Stigma and discrimination reduction for key and vulnerable populations

The data are clear that stigma and discrimination, across multiple different settings and relating to people living with HIV as well as members of key populations, persist as deep-rooted problems in Kenya, particularly in rural areas. It is critical that a broad range of programs be implemented at a sufficiently large scale to reduce this stigma and discrimination. A strong foundation of relevant programming exists that can be strengthened and scaled up. Interventions are needed from the community level to the national level.

In order to continue to tailor efforts to reduce stigma and discrimination for key and vulnerable populations, it will be important to repeat implementation of the Stigma Index (the latest national stigma report available is dated 2014) and other measurements of stigma (particularly in health care settings) to track the prevalence of stigma, its worst forms and where it manifests, and its reduction over time through strategic programs targeting it. Within this, it will be important to follow the new methodology that has been proposed to ensure adequate sampling from different key populations in survey administration. Repeat administration every two years will allow the tracking of changes over time, providing insight into the effectiveness of interventions being implemented. It is critical that the findings of these surveys be used to inform policy and programmatic interventions, so resources should be allocated to ensure widespread dissemination of findings and promotion of their use. In addition, support to communities to carry out targeted research, like that carried out recently by KESWA, can help build the evidence base around key population's lived experiences in the context of HIV.

Similar attention should be given to understanding TB-related stigma and discrimination, including how these differ from and intersect with HIV-related stigma and discrimination. Data around transgender populations, prisoners and migrants/refugees are sorely needed and may require targeted studies that would encompass stigma and discrimination as well as broader human rights barriers to accessing HIV, TB and malaria services.

Within any work to understand HIV-, TB- and key population-related stigma and discrimination, it is critical that due attention be given to gender (broadly understood) to unravel the different ways in which gender-based discrimination acts as a barrier to services for different populations and that any interventions – whether specifically to address stigma and discrimination or more broadly

to build capacity of duty bearers, promote access to justice etc. – be designed to be gender-transformative.

A national-level media campaign of human rights messages related to HIV and TB, focusing on stigma and discrimination reduction and key and vulnerable populations would target the general public. This could be done through television, radio and social media. Local-level programs using radio and in local languages could be more specifically tailored to sensitization for people in workplaces, schools, and religious, community and government leaders as most appropriate to each county (based on epidemiology, local stigma data etc.). Much can be learned from the work of the KP Reach program that was implemented in southern Africa and included a range of multi-media communications messages. However, it is also important to note that, under this program, M&C Saatchi developed media campaign materials specifically for use in Kenya but, due to in-country resistance, they were unable to actually run the campaigns (Personal communication).

These media campaigns will be completed, at the community and county levels, by sensitization of community leaders, religious leaders and members of county government on HIV/TB-related stigma and discrimination, human rights, and their roles in promoting rights and non-discrimination. The focus of sensitization should be tailored to local context (e.g. size of local key populations, findings from stigma index). Sensitization meetings with these stakeholders should be held every six months throughout the 5-year period, with additional technical and financial support for local non-discrimination campaigns/activities that participants wish to implement.

The importance of psychosocial support groups to address self-stigma has been widely acknowledged, but there has been diminishing support for these groups in recent years. There are 523 health facilities (health centers, medical clinics primary care hospitals) run by the government, non-government organizations or faith-based organizations in the ten focus counties²². Allowing 6 months start-up time for the grant, establishing 10 support groups per month over the course of the remaining 4.5 years would allow the establishment of one support group attached to each health facility. Distribution may vary as some facilities will benefit from more than one support group while others may be geographically close enough that one support group could serve multiple facilities. These support groups could also provide an entry point for supporting human rights literacy, monitoring health service provision and perhaps even recruiting potential human rights peer educators or paralegals.

At the community level, it will be important to promote safe access to key-population friendly services, in which information, mobilization and advocacy on human, legal and patients' rights is included. Response to violence and linkages to legal services as needed should be included as part of the package of services on offer. Advocacy by key population-led civil society organizations (or in the five counties with smaller key populations, vulnerable population-led organizations) to improve access to good quality services free from stigma and discrimination should be supported. The siting of these spaces will be critical to ensure client safety, and should be based on

²² Kenya Master Health Facility List. Accessed 7 May, 2020.

population preference. Facilities should include space where key population members can simply socialize in what they know to be a safe environment.

Increased investment in workplace and school programs to reduce HIV and TB-related stigma and discrimination and to increase awareness of NHIF and SACCO is also needed, and there is a good foundation on which this work can be built. In addition, an accessible system of redress for cases of TB-related workplace should be created. This should be widely advertised in schools and other workplaces alongside the existence of the HIV/AIDS Tribunal which constitutes an avenue of recourse in cases of HIV-related discrimination.

Much of the programming to reduce TB-related stigma and discrimination can be integrated with that to reduce HIV-related stigma and discrimination, however it is important there also be some TB-specific interventions independent of HIV. This responds to the epidemiology – we know that not everyone with TB has HIV – and can avoid compounding stigma by perpetuating the association with HIV. Of particular importance in the context of TB are workplace programs designed to reach men with anti-stigma messages, especially in the informal economy, including also matatu drivers and touts, boda boda drivers and men working in quarries. TB survivors have a central role to play in this programming work: their voice of experience can be powerful in media campaigns as well as sensitization of and dialogue with county, religious and other leaders.

In order to reach people with disabilities with HIV and TB services as well as HIV- and TB-related human rights information, collaborations should be established with existing efforts to reach people with disabilities with HIV and TB services so as to integrate human rights content into future trainings and materials.

(ii) Training for health care workers on human rights and medical ethics

In general, training for health care workers should be inclusive and include HIV, human rights, key populations, stigma reduction, non-discrimination, gender sensitization, youth-friendly services provision and medical ethics.

Two primary strands of work are envisaged under this program area: institutionalizing training on human rights and medical ethics relating to HIV and TB (and, ideally, malaria and broader service delivery efforts) in the context of working with key and vulnerable populations in pre-service training for all health workers, and institutionalizing the same in-service training of health workers, particularly those in key facilities providing HIV and TB-related care. In both cases, it will be important to map existing training efforts as well as the level of capacity for implementation of the training in order to inform standardized curricula and a training roll-out plan. For example, the curriculum for in-service training should include an initial training as well as quarterly follow-on sessions. The latter could be incorporated into continuing medical education efforts, but the initial training should be provided to everyone working within the health facility (including receptionists, orderlies, laboratory technicians etc.). Useful lessons might be learned, for both pre- and in-service training, from implementation to date of the

USAID-funded 'Gender and Sexual Diversity' training mentioned above (Health Policy Plus, 2015).

It will also be important to consider who is best placed to implement these trainings. Incorporating pre-service training into medical training institutes' curricula is a large task and will require coordination among all of the relevant training institutes. As of 2015, there were 102 approved nurse training institutions, 10 medical doctors training institutions and 36 clinical officers training institutions (although there may be some overlap between these) (Kenya Ministry of Health, 2015). Large-scale advocacy will be required to secure high-level support for this change to the curriculum as well as institutional commitment to see through the changes. Capacity-building of the faculty in human rights might also be required.

Furthermore, for the in-service training, any CBOs or NGOs who are providing training should have previously received training themselves on human rights and medical ethics beyond the curriculum which they will be teaching. Inclusion of representatives of key and vulnerable populations in the development and delivery of pre- and in-service training curricula should be a core tenet of this and all other training and sensitization described in this section.

In rural areas, training of community health volunteers (along with the provision of a stipend for them) can help ensure that support reaches the community, even in hard-to-reach areas, providing an invaluable continuity in support.

Training on human and patients' rights and ongoing support to community health volunteers is also needed, particularly in the context of TB.

While some information about experiences of discrimination within healthcare settings can be gleaned from the Stigma Index, there is not enough clarity regarding the degree and location of stigma and discrimination in health services. Thus, it is critical to make particular efforts to assess health worker knowledge of human rights and ethics as well as client experiences of stigma, discrimination and rights violations at the start of the grant period and then again at the end to assess progress under this program area. A number of validated stigma measurement tools exist that should be rolled out periodically in health care settings to do this.

(iii) Sensitization of lawmakers and law enforcement agents

Similar to the training for health workers above, the proposal is for a two-pronged approach to the sensitization of law enforcement agents. Standardization and implementation of pre- and in-service training for police, prison officers, and judges, magistrates and prosecutors are recommended. This means having a single curriculum for use with each one of these constituencies rather than the multiplicity of curricula currently in use. This will require initial advocacy and then longer-term collaboration with the national training institutions responsible for training each of these cadres as well as with CSOs who may be best place to carry out in-service training. The existing "training of trainers" manual for law enforcement agents will be a useful starting point for that target audience. As above, USAID's 'Gender and Sexual Diversity' training might also be a useful resource. In order to create sustainability around these trainings,

the following should be planned for: faculty training every two years, refresher in-service training, outreach to senior officers/law-makers/magistrates nationwide to bring them onboard, monitoring mechanism for accountability including incorporating quality of service provision into performance contracts/continuous assessment, and curriculum review (pre- and in-service) every two years. Pre-service training for police can use as its starting point the current module on “Human rights, police ethics and accountability”, but this will need to be expanded and tailored to HIV and TB. In-service refresher training should be guided by findings of legal environment assessments or community-based monitoring of law enforcement agents.

With approximately 45,000 regular police officers nationwide, it will be important to focus on the ten priority counties, with an aim of training 500 officers over four years. While this number appears small, it is critical that the quality of the training be very high, which can limit overall numbers, particularly initially. Once pre-service training is institutionalized and a group of officers with in-service training has been created, it will become possible to think about training of trainers as a way to cascade training through the force and ensure a broader reach.

Similarly, it will be impossible to reach the 22,000 staff of the Kenya Prisons Service but targeting 240 staff over four years is feasible. There are 600 judicial officers in the country. Years one and two will be spent creating an appropriate in-service training curriculum and building capacity to deliver this training curriculum. From years three to five, 50 judicial officers will be trained every quarter. Training will take place over a set number of days (to be determined) in Nairobi, meaning that the costing will factor in transportation and per diem in addition to the costs of the training itself. In addition, the new cadre of senior legal researchers and legal researchers recently hired to help judges should also receive training. Training of twenty of these researchers could be integrated into the training of judicial officers.

As with the training of health workers, the central involvement of key and vulnerable populations in the design, implementation and monitoring of all trainings is vital, as are joint activities at the district level between these populations and people who have participated in the trainings. An example of the latter would be regular (monthly) meetings to share experiences of the current reality both with regard to duty bearers’ implementation of what they learnt during training and key and vulnerable populations’ experiences in their interactions with these duty-bearers. These meetings could then link to appropriate channels of redress so that unresolved issues can be pursued through official channels, such as the ombudsperson or the HIV/AIDS Tribunal.

It will also be important to sensitize Court Users’ Committees on HIV, TB and human rights to support their role in ensuring access to justice. These committees are a good example of a mix of duty-bearers and rights-holders which is known to open space for important mutual capacity building about HIV and TB-related rights as they exist on paper and as they are experienced. They constitute a useful entry point to justice system for this work. Two Court Users’ Committees per priority county should be sensitized over the course of the project, with sensitization including quarterly meetings for two years during which the time is to embed HIV and TB into their regular agenda. Refresher sensitization meetings might be carried out after two years.

In-service training for all of these elements of law enforcement should be prioritized in the five counties with large numbers of key populations whom, evidence suggests, are at disproportionate risk of human rights violations. Training should then be rolled out to the other five priority counties as vulnerable populations in those counties also face challenges with which supportive law enforcement could better assist.

Regular sensitization of parliamentarians can help ensure attention to human rights and dignity in HIV and TB-related laws, and useful entry points exist for this work including the Parliamentary Committee on Health and the Kenya TB Caucus. This 'sensitization' should comprise representatives of key and vulnerable populations being given the opportunity to openly discuss how their lives are affected by laws relevant to HIV, TB and key or vulnerable populations.

(iv) Legal literacy ('know your rights')

Data indicate a need for ongoing legal literacy activities with a range of stakeholders, which can help ensure that everyone receives the quality health and related services to which they have a right and ultimately bring Kenya closer to its national and international targets relating to HIV and TB. The media campaign described under 'reducing stigma and discrimination' above might help support legal literacy among the general population. Alongside this, targeted efforts for specific stakeholders focusing on building legal and patients' rights literacy can usefully complement this general effort. Building on the foundation of work that has already been carried out in this area, suggested stakeholders for targeted training include key population and vulnerable population support groups; community, religious and county leaders; and teachers and parents.

Building on the existing NASCOP manual for training peer educators for programs with female sex workers, standardized manuals for peer educators in different key and vulnerable populations should be created. There is also a training manual, produced by KELIN, on the Patients Charter that has been used to train a number of people living with and those affected by TB, which could be a useful resource for this work.

Legal literacy could usefully be integrated into ongoing structures to address HIV and TB. While existing peer educators focus, to a large extent, on education around disease management and ensuring linkage to services, the content of training could be expanded to also include legal and patients' rights and addressing HIV- and TB-related stigma and discrimination. For example, community health workers who are supporting people living with HIV and people with TB in the communities could be trained to also provide information on legal and patients' rights including the Patients Charter, the health care to which they are entitled, and how to access avenues for redress in case their rights are violated. This will capitalize on the experience of existing peer educators while expanding their knowledge base and the service they can provide.

Furthermore, peer educators with this type of training can help mobilize communities to engage in the design and monitoring of relevant laws and policies so as to ensure appropriate community inputs, track implementation and hold government to account. This means building on some of the existing peer education work currently being carried out, including with funding from the Global Fund, USAID and OSIEA. Additional peer educators across all key and vulnerable populations will also need to be recruited.

Coordinated implementation of this training should be carried out in priority counties, with high involvement of key populations organizations in design and implementation of the training. While legal literacy efforts will have to be tailored for each constituency, there could be a core common curriculum (and even standardized materials for different constituencies). It is critical that these efforts include not only information about people's rights (including patients' rights) but also how to engage in legal and policy processes, how to demand better services, and where and how to seek assistance in any case of perceived rights violations. Legal literacy should lead to mobilization, advocacy and action.

Peer educators will require ongoing support to carry out their functions. This includes remuneration not only for costs incurred carrying out their work but also for their time, as well as ongoing mentoring and technical support. The latter could be provided through tiers e.g. seasoned peer educators could mentor more recent recruits and receive their own technical support from an NGO, perhaps even the one who has coordinated trainings. Structured reporting of peer educators to the support NGO (and even up to the principal recipient of the Global Fund grant) can help track their levels of activity, the types of support requested and received, the main issues they have helped to address, and any persisting or emerging knowledge gaps.

Power dynamics are an important consideration for any legal literacy work with community, religious and county leaders as well as teachers and parent teacher associations. Community peer educators should remain central to these efforts but it may be important to also include civil society representatives known to these leaders to ensure that the seriousness and relevance of the training content is understood.

It is also important that some entry points for legal literacy on HIV and TB are TB-specific so as reach populations at risk of TB (who may not be at such high risk of HIV) such as urban slum dwellers, miners, boda boda drivers and refugees and other mobile populations. This could be done, for example, through TB treatment supporters or TB community peer educators.

Legal literacy training is a highly technical area. This should be carried out by civil society organizations with expertise and experience in law and human rights, particularly as they relate to HIV and TB.

(v) HIV and TB-related legal services

A range of avenues exists to strengthen existing HIV and TB-related legal services, and the Legal Aid Act (and policy) provides useful guidance for implementation.

Paralegals are a much-used mechanism for promoting access to justice in Kenya with many different organizations having trained paralegals from different communities. As with other recommended training efforts, it would be useful to create a standardized training curriculum on HIV and TB for paralegals (that could be incorporated into the accredited paralegal training curriculum) that leads to certification. This training could then be rolled out across different communities.

The National Legal Aid Action Plan includes two-week human rights training for paralegals (for which there is a training handbook), which might constitute a useful resource to which to append additional training relating to HIV (and TB). Just as paralegals who undergo the two-week training receive an accreditation, so too should anyone who takes the additional HIV and TB training.

Training curricula for community paralegals could be more narrowly focused than the above-mentioned two-week training, focusing only on HIV- and TB-related laws and rights. The curriculum for this could build on existing training manuals (e.g. NASCOP manual for training peer educators for programs with female sex workers) to create standardized training materials for different populations. It will be important to also institute standardized remuneration guidelines, provide logistical support and monthly stipends, and create an effective monitoring mechanism for paralegal activities. Paralegals based in health facilities could be provided a system through which to report illegal or non-procedural facility-based actions (see *Monitoring and reforming policies, regulations and laws* below).

Some cases are beyond the capacity of paralegals and require the intervention of a lawyer. Training a pool of lawyers on HIV, TB and human rights who are willing to do *pro bono* work on these cases is another way to improve access to justice. Complementary to this, although these lawyers are giving their time and expertise for free, there is a need to support the ancillary costs of taking on a case such as transport, allowances, airtime and stationery.

It will be useful to create links between the paralegals and this cadre of *pro bono* lawyers so that paralegals might be used as a first port of call and then they can access additional legal support if needed. Perhaps building on KELIN's existing database of *pro bono* lawyers, county-level databases of peer educators, paralegals and *pro bono* lawyers would facilitate networking between these different cadres, facilitating networking, mentoring, support and referrals. These databases should include all paralegals even if they have not been specifically trained on HIV and TB (although this should be noted in the database): they may still be able to provide services in places where specialist HIV and TB knowledge is lacking, and the database could help network them to professionals with this specialist knowledge who might support their work. This could include paralegals trained by Kituo Cha Sheria through the Legal Aid and Education Program as well as their Community Justice Centers. This might fit with broader national plans, under the current UBRAF, to create an inventory of institutions working on HIV, human rights and the law.

The Court Users Committees appear to be another important element of the legal apparatus in Kenya, particularly with regard to strengthening the safety net around a case by highlighting sensitivities of particular cases and ensuring that plaintiffs know about the support systems available to them. Capacity building of these committees will help ensure that, in HIV- and TB-related cases, the Committee members know how best to advise plaintiffs.

Support is needed for key-population run 24/7 hotlines through which advice can be provided on human rights and how to seek access to justice. The BHESP hotline can be used a model.

Given the decentralized nature of health in Kenya, it seems important that the HIV/AIDS Tribunal also be decentralized at least to some degree. This is likely a complicated process as it might include an amendment to the HIV and AIDS Prevention and Control Act, 2006 (which currently requires the HAT Chair to preside over cases) as well as restructuring the governance, budget and accountability mechanisms (key informant interview 41).²³ While decentralization to all 47 counties might seem unrealistic in the short term, a first step might be to bring the Tribunal down to 'clusters of counties' thereby increasing accessibility somewhat (key informant interview 28).

Advocacy campaigns to create awareness of HIV-related rights as well as the Tribunal itself will also be needed, particularly for people living with HIV and members of key populations as well as community gatekeepers. Raising community awareness about the different avenues of legal support that exist in the context of both HIV and TB, including the HAT, Court Users Committees, paralegals and *pro bono* lawyers will help stimulate demand for these services and ensure that people know how to effectively access these mechanisms. This should include community-level work, as well as key population-specific hotline services, that people can call for advice on their rights how to seek access to justice.

Building the capacity of the National Legal Aid Service Board can support the fulfilment of its mandate to roll out the Legal Aid Act and policy.

(vi) Monitoring and reforming laws, regulations and policies

While some mechanisms and capacity already exist for monitoring and reforming laws, regulations and policies, there is a great need to further develop the capacity for this work. Part of this relates to strengthening existing mechanisms, some relates to capacity building of specific stakeholders (e.g. civil society, county officials), and some relates to financial and/or technical support to carrying out this type of monitoring work.

In the era of devolution, it will be important to ensure that structures exist to facilitate civil society engagement in county-level planning, budgeting and policy-making as well as in civil society monitoring of implementation of policies, plans and budgets. These are currently variable across the different counties; strengthening these structures where they are currently lacking or weak will help ensure that civil society can feed into these processes. This will require training of county-level health officials as well as local civil society organizations working on law, human rights, HIV and TB. Regular meetings between county health officials, people living with HIV, people with TB, and other key and vulnerable populations will be critical fora for promoting open discussion about ongoing and emerging issues. Where strong networks of paralegals exist they might also be a good entry point for some of this work. However, recognizing the diversity of key

²³ Personal communication

and vulnerable populations as well as the heterogeneity within each population will be critical for ensuring that all appropriate constituencies can be reached.

Attending training and participating in meetings is, however, insufficient; concrete action plans with measurable, timebound indicators should be developed and mechanisms for accountability made clear. For example, links to ombudspersons should be highlighted as well as the potential for strategic litigation or other more adversarial approaches should they be required. The work of the URAIA Trust in county budgeting (including health budgets) and social accountability²⁴ might usefully be adapted to the context of HIV and TB. In addition, regular implementation of community scorecards such as the 2015 MSM Health Scorecard²⁵, developed and implemented by AIDS Accountability International, AMSHER and Ishtar, will help monitor the situation for different populations. With different scorecards available for different populations, two scorecards could be implemented nationally every year, with repeat scorecards after three years to monitor progress. Focus counties would be useful targets for regular county-level scorecards. It will be important to identify populations for whom no specific monitoring tools are available in case additional tools might need to be developed.

Different key and vulnerable populations are affected differentially by laws, regulations and policies affecting access to services – for some there remains a policy void (e.g. trans people) while for others, greater recognition has been achieved at least in the policy sphere. This creates an argument for prioritizing work to create policy protections where none currently exist. However, alongside this a pragmatic approach that takes advantage of any opportunities to monitor and influence laws, regulations and policies to ensure systematic attention across all relevant populations.

One useful entry point for civil society community based human rights monitoring will be the existing community health advocates who carry out volunteer work in the community even as they are not recognized formally as community health volunteers. These community advocates specifically work to raise awareness on HIV and TB rights, increase treatment literacy, and demand for quality health care services among the community members within their counties. They also monitor, document and report rights violations. These community health advocates could work with paralegals situated within health facilities to provide a continuity of services. Where there is no paralegal available within a health facility, the community health advocate, with appropriate training, could fulfil this role as many of them already have links to health facilities. Both could report violations to the county-level ombuds-system, opening up to community members this avenue for seeking redress. In conformity with Legal Aid Act, paralegals would report to the National Legal Aid Service. The geographic scope of this work should be expanded to all ten focus counties.

In addition to all of these activities that integrate monitoring and reform efforts for HIV and TB, scaling up the work of the community TB advocates (whose scope could also be expanded to include HIV) will improve monitoring of violations. The type of innovation underlying 'Imonitor'

²⁴ <https://uraia.or.ke/wp-content/uploads/2016/11/Handbook-on-County-Planning-County-Budgeting-and-Social-Accountability.pdf>

²⁵ <http://www.aidsaccountability.org/wp-content/uploads/2015/02/AAI-AMSHer-African-MSM-Health-Scorecard-Kenya.pdf>

should be encouraged; this could be done through funding a competitive social entrepreneurship endeavor to create an innovative way to monitor TB-related laws, regulations and policies.

The above-mentioned county-level networks of community health advocates, peer human rights educators, paralegals and *pro bono* lawyers can be critical for monitoring and reforming laws, regulations and policies. With a coordinating body at county-level, this would be a mechanism for the consolidation, auditing and analysis of HIV- and TB-related human rights violations experienced by people living with HIV and other key and vulnerable populations as well as the outcomes of any efforts to seek redress.

The advocacy sub-committees of key population technical working groups are a particularly important structure through which the meaningful engagement of key populations in HIV and TB responses can be promoted. Financial support to these groups, particularly at the county level, could usefully promote participation by a wide range of key population representatives. This should be done in all 10 focus counties, starting with the five with the largest numbers of key population members.

While the capacity building activities proposed across the different program areas of this package of interventions are critical, it is well accepted that training alone is insufficient for behavior change. Given that many of these activities will be concentrated in the same geographic areas, there is a key opportunity for creating multi-stakeholder groups of the different cadres trained by locality including a mix of the different officials trained as well people living with HIV, people with TB and other key and vulnerable populations. These groups should meet quarterly to discuss issues relating to HIV, TB and human rights as relevant to everyone in the group (whether in their work or their lives), to plan joint activities, to discuss challenges, and to provide an opportunity for advocacy and accountability. Although the groups will need a convening organization (likely one of the organizations leading capacity building efforts locally), it is critical that joint ownership be engendered and that funding be available for joint activities between meetings. This will help create a pool of champions who can work together to promote rights-based responses to HIV and TB, calling on one another for support as required.

The regular turnover of Parliamentarians can make them a difficult constituency to engage, but the Parliamentary Health Committee is a critical entry point for ensuring that law-makers are apprised of contemporary issues relating to HIV, TB, human rights and the law. Regular fora, attended by health professionals, people living with HIV, people with TB and representatives of key and vulnerable populations can help keep these issues on the political agenda. With an appropriate understanding of the issues, this Committee can play an important role in promoting oversight and accountability.

Support to the NACC technical working group on HIV, human rights and the law could usefully facilitate capacity building to ensure that group members can remain updated as HIV science as well as relevant jurisprudence evolve. The group is also well placed to carry out targeted research to inform legal reform as might be needed. Ideally, technical working groups would be established in all priority counties but this might be a longer-term objective.

(vii) Reducing discrimination against women in the context of HIV

There is a wealth of programming on women and HIV in Kenya, but much of it lacks a specific rights focus. However, it provides a framework into which rights-focused work might be integrated even as rights-specific interventions will also be needed. The interventions proposed under all of the human rights program areas in this assessment can (and should) be done by and for adolescent girls and women. While this a broad recommendation, it can be operationalized by instituting a gender review of all activity plans prior to implementation to assess the extent to which all efforts (such as peer human educators, paralegals, measuring and addressing stigma and discrimination in the context of health care, patients' rights in the context of health care etc.) are adequately tailored to meet women's specific needs. This is also true for programming for specific populations such as prisoners and incarcerated populations, people who use drugs and transgender people, where explicit attention to women and their needs is critical. This is a critical recommendation as it will require that, once this assessment is complete, any plans for reducing discrimination against women in the context of HIV (as well as addressing gender as a determinant of access to HIV, TB and malaria services more broadly) will need to be re-visited, using the emerging evidence to tailor them as appropriate to the identified needs. This process should include multiple multi-stakeholder meetings to facilitate participatory planning for acceptable and feasible programming.

Legal literacy for women and girls (including those belonging to key and vulnerable populations) should be incorporated into other activities targeting these populations in the current funding request. Additional capacity building of community, religious and county leaders on gender and rights as they relate to HIV and TB could also be scaled up.

While the National Monitoring and Evaluation Framework toward the Prevention of and Response to Sexual and Gender Based Violence in Kenya is seen as survivor-centered, some informants suggested the need for additional attention to psychosocial support alongside increased involvement of families and communities (key informant interview 15). This could be coupled with legal literacy efforts and integrated into ongoing programs to address gender-based violence e.g. GVRC, DPHK, NEPHAK, COFAS.

Creating a pool of funding to support alternative dispute resolution for gender-based violence (and perhaps other HIV-related cases) might help increase access to justice where the court system is inaccessible. Successful examples of alternative dispute resolution can be used to inform scale-up of these activities through peer mechanisms, including peer paralegals and key-population-led civil society organizations. This will require capacity building to enable additional civil society organizations to take on this function as was as financial support to this work moving forward.

Advocacy, implemented by trans-led organizations is needed to improve legal protections for trans women. This will require capacity building during the first year, with refresher training provided in years three and five, with ongoing support to advocacy (i.e. budget for meetings, materials etc.) throughout the grant. At least one trans-led organization in each of the five priority

counties with large trans populations should be included as well as the national and regional networks.

(viii) Reducing gender-based barriers to TB services

Repeat administration of TB/HIV gender assessment tools will help track changes over time. Using this tool to inform gender-sensitive TB programming in high burden counties should be prioritized. In addition, TB workplace programs should be implemented, particularly in male-dominated informal workplaces, where the burden of TB is known to be high and uptake of services low.

Training of and support to male community health volunteers on human rights and gender-related issues should be part of the broader community health volunteers described elsewhere in this proposed comprehensive package of services. The focus for community health volunteer training and the appropriate mix of participants will have to be locally determined on the basis of culture and disease burden.

Community members voiced a strong desire for TB services to be systematically integrated into existing drop-in centers so that key populations can take advantage of the extended opening hours, but they should also be availed through 'regular' health services for people with TB who do not have HIV or do not wish to attend a drop-in center. Supporting advocacy for both of these interventions will improve access to quality TB services.

A focus on informal settlements, refugee camps and communities of fisherfolk is recommended for this work.

(ix) Opportunities to strengthen ensuring confidentiality and privacy

This work should be mainstreamed throughout all of the program areas. Whether training duty-bearers, carrying out legal literacy work, or mobilizing patient and community groups, ensuring confidentiality and privacy should be a core message.

(x) Mobilizing and empowering patient and community groups (TB)

The existing programs identified under this area focus almost entirely on good public health interventions. This provides a platform into which to integrate human rights-focused interventions such as addressing stigma and discrimination, improving legal literacy and promoting access to justice.

Empowering patient and community groups is key to the TB response. There is a strong basis of programming that can be strengthened and expanded. Training for and ongoing support to community health volunteers to play an explicit role in promoting human rights and patients' rights is a central piece of this work and will require substantial investment that builds upon activities in the current Global Fund grant as well as other ongoing interventions. The community-based monitoring mechanisms described for HIV and TB above might be useful points of connection for the TB community.

The creation of a network of people affected by TB, that the above community groups would be connected to, can help streamline and coordinate a rights-based response across the country and avoid fragmentation of efforts. Such coordination should be led by people affected by TB and, therefore, a national-level network is needed. Upon formation, network members will require legal literacy training to ensure a baseline of capacity for attention to rights in this coordinating and monitoring role. Stop TB's national network of TB advocates might form the basis for this proposed network.

Social protection for people with DR-TB, currently provided by the NTLD Program should be closely monitored to ensure that it is having the desired impact and advocacy for accountability should be supported. Furthermore, legal literacy activities could be integrated into this program, which is designed to reach some of the most vulnerable. This would also be a useful entry point for create psychosocial support groups for people with TB to help address self-stigma

(xi) HIV and TB programs in prisons and other closed settings

Addressing HIV and TB in prisons and other closed settings has been severely under-prioritized to date. There is immense scope for strengthening these programs and a solid foundation on which to build, particularly through the work of HealthStrat with the AIDS Control Unit of the Kenya Prisons Service.

Training materials on HIV, TB and human rights in prison should be developed and, over the course of the next five years, rolled out to prison administrators and staff across the country. Given the crowded conditions in prisons and the high risk of TB transmission, this activity should not be limited to the ten priority counties.

Building on the work carried out by Healthstrat and the AIDS Control Unit, psychosocial support groups to address self-stigma among prisoners living with HIV or TB should be supported in all prisons in the ten focus counties.

There is large scope for advocacy to increase budget and actions to improve interventions to address HIV and TB in prisons and other closed settings. For example, advocacy to expand access to medication-assisted treatment for people who use drugs and to increase access to condoms could increase access to services in these settings. At a broader level advocacy, there is an urgent need to address the current prison infrastructure so as to provide medical isolation facilities in prisons to ensure the appropriate treatment of prisoners with TB. In addition, given the transitory nature of the prison population and the current lack of follow-up of people with HIV or TB when they are released into the community, advocacy to ensure that health information systems be networked between closed settings and MOH health facilities outside the prison system is critical. While this advocacy is focused in the ten priority counties, it should also take place at the national level as many of these issues are determined through national policy, which means that any changes would have impact beyond the ten focus counties.

Legal literacy training should be provided for prisoners and incarcerated populations to help them understand their rights and the legal processes they are in; this should cover not only HIV- and TB- related rights but also human rights relating to malaria. A cadre of peer human rights educators should be created within each prison (and will have to be regularly refreshed due to transitions into and out of prison) to promote legal literacy in relation to HIV and TB. This could be added to existing training of ‘cough monitors’ by Healthstrat to identify and refer prisoners who might have TB for early diagnosis. Training 40 inmates per facility should ensure adequate coverage.

In addition, scaling up the provision of mobile legal services in preparation for parole hearings can help reduce costs and promote access to justice.

The transition back into the community after prison can be particularly challenging, with potentially negative impacts on adherence to treatment. Psychosocial support groups should be established for people with HIV or TB who have been recently released from prison to help address fear of stigma during this transition and promote understanding of HIV- and TB-related rights in the community.

(b) Malaria Programs

Activity	Level of intervention	Scale of intervention	Lead institution	Timing and frequency of activity
Human rights and gender assessments				
Advocacy to strengthen HMIS and KMIS to enable better disaggregation of malaria data	National	National	CSOs	Y1-5 as needed
Follow-on assessment on gender and human rights in the malaria (to assess progress since previous assessment) and to ensure recommendations from first assessment have been supported and carried out	County	Counties with endemic or seasonal malaria	CSOs	Y3, Y5
Assessment of barriers to accessing services among mobile populations	Community	Counties with nomadic populations	CSOs	Y1

Activity	Level of intervention	Scale of intervention	Lead institution	Timing and frequency of activity
Meaningful participation of affected populations				
Ongoing support to the inclusion of human rights and gender issues/information into multi-sectoral TWG on malaria including government and civil society at national and, in counties with malaria, county level	National and county	National and counties with endemic or seasonal malaria	NMCP, CSOs	Y1-5
Capacity building of civil society representatives to identify and address human rights and gender issues in in policy design and of implementation of malaria services: - Development of a training curriculum - Capacity building in counties affected by malaria	County	Counties with endemic or seasonal malaria	CSOs	Y1: curriculum development Y2-5: gradual roll out across all affected counties
Capacity building of duty bearers on malaria-related human and patients' rights and sensitization on the importance of community engagement - Development of a training curriculum - Capacity building at national level and in counties affected by malaria	National and county	National and counties with endemic or seasonal malaria	CSOs	Y1: curriculum development Y2-5: gradual roll out across all affected counties
Strengthening of community systems for participation in malaria programs				
Support advocacy for policy reform to ensure a supportive policy for community health volunteers to administer rapid diagnostic tests and provide treatment, and to receive standardized payment	National	National	CSOs	Y1-5 as needed

Activity	Level of intervention	Scale of intervention	Lead institution	Timing and frequency of activity
Map existing training curricula for community health volunteers so as to ensure inclusion of malaria-related gender and human and patients' rights issues	National and county	National and counties with endemic or seasonal malaria	NMCP and CSOs	Y1
Once there is clarity regarding community health volunteers' role around rapid diagnostic testing, develop a coherent training curriculum for community health volunteers to cover all aspects of CCMM, gender and human rights for incorporation into broader training curricula	National	National	NMCP and CSOs	Y2 (or as soon as clarity on the currently evolving policy environment is reached)
Training of community health volunteers to engage in human rights and gender issues throughout areas with malaria, including in hard-to-reach communities	Community	Counties with endemic or seasonal malaria. Focus on informal urban settlements	CSOs	Y3-5
Capacity-building of civil society to engage in community monitoring of budgets and interventions as well as advocacy for accountability	Community	Counties with endemic or seasonal malaria.	CSOs	Y1-5:
Adoption, evaluation and expansion of the iMonitor community-based monitoring mechanism to provide real-time feedback on malaria services delivery	Community	Counties with endemic or seasonal malaria.	CSOs	Y1: institute the system; Y2-5: monitor its implementation
Addressing gender-related vulnerabilities and barriers				
Legal literacy for women including on rights relating to malaria during pregnancy	Community	Counties with endemic or seasonal malaria	CSOs	Y1-5: gradual roll-out across affected counties

Activity	Level of intervention	Scale of intervention	Lead institution	Timing and frequency of activity
Advocacy for increased distribution of LLINs	Community	Counties with endemic or seasonal malaria	CSOs	Y1-5 as needed
Advocacy to change the school health curriculum with information on malaria and human rights including malaria in pregnancy and harmful gender norms	Community, county, national	Counties with endemic or seasonal malaria	CSOs	Y1-5 as needed
Community education of men and community and religious leaders to challenge harmful gender norms	Community	Counties with endemic or seasonal malaria	CSOs	Y1-5: gradual roll-out across affected counties
Improving access to services for refugees and others affected by emergencies				
Research to better understand inequities in access to malaria services and interventions within refugee camps		Refugee camps	CSOs	Y1
Advocacy for increased and equitable IRS and LLIN distribution in refugee camps: training of peer human rights educators	Community, county, national	Refugee camps	CSOs	Y1, Y3, Y5
Community monitoring of IRS and LLIN distribution in refugee camps and support for actions to seek redress if this is not occurring equitably	Community	Refugee camps	CSOs	Y1-5
Include community health volunteers from refugee camps in above-described training	Community	Refugee camps	CSOs	Y2-5
Advocacy for support for implementation of pre-elimination interventions in host communities	Community, county, national	Communities surrounding refugee camps	CSOs	Y1-5 as needed

Activity	Level of intervention	Scale of intervention	Lead institution	Timing and frequency of activity
Improving access to services for people living with HIV				
Develop SBCC materials on malaria for use in support groups of PLHIV		Counties with endemic or seasonal malaria		Y1: material development Y2-5: distribution, training, monitoring of impact
Improved services in prison and pretrial detention				
Advocacy for improved malaria prevention infrastructure as well as prevention, diagnostic and treatment capacity (including, for the latter, in areas without malaria)	Institution, county, national	National	CSOs	Y1-5 as needed

(i) Human rights and gender assessments

Advocacy to ensure the availability of sex-disaggregated data through the routine health management information system, as well as the Kenya Malaria Indicator Survey, is critical to improving the understanding of human rights and gender in the national malaria response.

The recommendations of the assessment on community, rights and gender in the malaria response are yet to be fully implemented. Many of the recommendations have been picked up and included in the proposed package of interventions below.

In addition to this, an assessment on gender and human rights in the malaria response, as a follow-on to the assessment recently carried out by KeNAAM, should be planned toward the end of this five-year period. This should include an assessment of how gender influences risk of malaria exposure and access to services and interventions with a view to informing gender-transformative responses for both women and men.

An assessment of barriers to accessing services among mobile populations is proposed, potentially using the Malaria Matchbox tool. This is broader than just malaria services, but malaria is a useful entry point given that most services are provided through primary health care. Participatory research studying the ecosystem of mobility within Kenya, the different populations who are mobile, the duty-bearers and other communities who come into contact with them, and

factors influencing mobility will help understand the nuance of population mobility and how best to ensure their uninterrupted access to services.

(ii) Meaningful participation of affected populations

With human rights now recognized as a guiding principle in the national malaria strategy, the door is open to community participation and advocacy to ensure that this principle is in fact mainstreamed into the national response. Participation of affected populations in the national (sub-national and local) response requires that structures be in place to facilitate this, that policy-makers and government programmers be receptive, and that affected populations have the capacity to participate meaningfully. The multi-sectoral technical working groups on malaria that exist at national and county levels require ongoing support to facilitate interaction between government and civil society. Capacity-building of government officials at national and county level on their malaria-related human rights obligations and sensitization on the importance of engaging affected populations can benefit from similar efforts that have been carried out to date. The same is true for human rights capacity-building of civil society/community representatives to engage in the national response. In these capacity-building efforts it will be important to include organizations representing the uninsured as well as people with disabilities whose needs are often not sufficiently addressed in current responses.

The very limited capacity among civil society organizations to address human rights in the context of malaria has been a real impediment to large-scale programming to date. This is evidenced by the limited programs on malaria and human rights identified during this assessment. In order for implementation of any of this proposed package of services to be feasible, large-scale capacity building of civil society organizations on malaria and human rights is required. This could include civil society organizations currently working on malaria from a health perspective by introducing them to the relevance of human rights as well as organizations working on health and human rights to help them understand the connections within the context of malaria. The former is important to ensuring that at the structural and service delivery levels (whether at the health facility or the community) human rights are appropriately considered. The latter is important for incorporation of attention to malaria into human rights monitoring, mobilization and advocacy efforts. Human rights should be incorporated into the terms of reference of the national malaria health sector technical working group and the county committees of experts in counties with endemic and seasonal malaria, with appropriate metrics for fulfilment of this function. Within health facilities in malaria-affected counties, training of health workers on why and how they should incorporate attention to human rights into their day-to-day work could be introduced as a 'continuing education module' on malaria and human rights.

(iii) Strengthening of community systems for participation in malaria programs

Community health volunteers are lynchpins for community participation in malaria programs. The recent court case that successfully challenged the ability of community health volunteers to administer rapid diagnostic testing for malaria severely limits community access to rapid diagnosis. Advocacy for a revised policy on community health volunteers' role in the malaria

response is needed to create pressure for accessible diagnosis and treatment of uncomplicated malaria within communities.

If such a policy change is effected, community health volunteers will require training to fulfil their new mandate. This is an opportunity for incorporating training on gender and human rights into community health volunteer training: they can serve as peer human rights educators helping to ensure that community members understand their human rights and patients' rights in relation to malaria, that they know where they can access further information and assistance if they feel as though their rights have been violated, and that they can engage in ongoing monitoring of malaria interventions and services. Building on the work under the current Global Fund grant, efforts should be made to standardize a community health volunteer training curriculum (that includes any new roles emerging from a developing policy environment as well as explicit reference to patient rights, confidentiality, informed consent) and expand training of community health volunteers beyond the areas covered by the current grant. In this program expansion, it will be critical to include urban informal settlements in malaria endemic and seasonal counties that are currently excluded from community case management interventions. This might be done in conjunction with the community health volunteer training recommended as part of the TB program above.

If the current Global Fund malaria grant attains its objective of 50% population coverage with community case management of malaria in lake endemic areas, this still leaves 50% of the population in these counties unreached with these interventions. On top of that, populations in coast endemic areas as well as counties with seasonal malaria are unreached. Targeted roll-out should target these gaps even as refresher training for community health volunteers in areas that are already 'covered' may be needed. The current grant plans for refresher training every three years.

Community monitoring of budgets (allocations and expenditures) and interventions, including the quality of community health volunteer interventions, also needs to be strengthened. Building on KENAAM's work in this area to date, capacity-building of civil society organizations to continually monitor the activities of county health assemblies, health workers and community health volunteers in this regard and carry out advocacy to increase appropriate and sufficient malaria interventions and push for governmental accountability for quality service provision. Monitoring budgets and interventions to address malaria in pre-trial detention and prisons, as well as refugees targeting refugees, forest-dwellers, people with disabilities and other traditionally 'left behind' populations should be an explicit part of this work.

In addition, building on work to date to assess the quality of malaria services, the iMonitor app, a community-based monitoring mechanism for the engagement and feedback on service delivery within HIV, TB and malaria could constitute a useful mechanism for accountability. Findings from the recent pilot test of this mechanism should inform the adoption, evaluation and roll-out of this community-based monitoring mechanism.

(iv) Addressing gender-related vulnerabilities and barriers

Given the low uptake of intermittent preventive treatment for malaria during pregnancy, especially among adolescent girls and other women who face barriers accessing health services, legal literacy interventions are much needed. These would cover information on rights related to malaria (including during pregnancy), community mobilization to demand access to quality malaria services, and avenues for redress in the case of suspected human rights violations. Female peer educators should be trained to carry out this work in counties with endemic or seasonal malaria. This work could complement or be integrated into PMI-supported work to encourage early attendance at ANC and receipt of appropriate malaria services in Bungoma, Busia, Homa Bay, Kakamega, Kisumu, Migori, Siaya and Vihiga.

Advocacy for increased distribution of LLINs can also help to overcome gender-related barriers noted above such as the need for additional nets in a household, as pregnant women often sleep separately from their partner, leaving one partner or the other exposed if there is only one net per two household members.

As noted above, there have been some efforts to provide malaria education in schools which, to date, this has not included attention to human rights or gender. Advocacy to change the school health curriculum to include information on malaria in pregnancy might help reach adolescent girls who become pregnant and help them understand the importance of attending antenatal care. Advocacy for changing the curriculum should also target the engagement of boys to educate them to be supportive of their partners to promptly access malaria services without requiring male approval.

Community education targeting men, community leaders and religious leaders to encourage men to recognize malaria symptoms, to support their partners to seek care in a timely manner without permission, and to challenge other harmful gender norms should be incorporated into the other community health volunteer activities recommended above. Regular sensitization meetings should be held with participants asked to report back each time on the relevant activities they have carried out in the interim. Funding should be made available for community and religious leaders to convene additional activities at community level in between these meetings.

(v) Improving access to services for refugees and others affected by emergencies

Malaria services for refugees have been under-prioritized to date. Given the lack of data on inequities in access to malaria interventions and services within the camps, research is required to help target malaria-related interventions in this context. It should be carried out as early as possible in the grant to inform subsequent interventions during the grant period.

Peer human rights educators should be trained to raise awareness of refugees' malaria-related rights (as well as HIV- and TB-related rights). They should be supported to carry out community mobilization and advocacy for increased equitable access to key interventions such as indoor residual spraying and bednets. There should also be support for community-based monitoring of

these interventions as a form of social accountability, including support to seek redress in the case of suspected human rights violations.

All of the malaria-related interventions for community health volunteers described above are also critical actions within refugee camps to ensure timely diagnosis and access to care. Any training of community health volunteers on these issues (and also on human rights relating to HIV and TB) should purposely include community health volunteers within the refugee camps.

Given that refugee host communities can receive fewer malaria-related interventions than the refugees themselves, advocacy is needed for implementation of pre-elimination interventions in host communities. This can be integrated with other advocacy efforts relating to human rights-related interventions for malaria.

(vi) Improving access to services for people living with HIV

As part of HIV service delivery, social and behavior change communication materials should be produced specifically targeting people living with HIV to help them understand their malaria risk, help them recognize symptoms and encourage early treatment-seeking. The use of these materials through support groups for people living with HIV should be supported.

(vii) Improved services in prison and pre-trial detention

A multi-pronged approach is needed to improve malaria services in prison and pre-trial detention.

Advocacy to improve police cell and prison infrastructure to promote malaria prevention and to increase availability of malaria prevention, diagnosis and treatment within prisons and pre-trial detention could be integrated with the similar advocacy requests being proposed under the TB section. Given the mobility of prisoners from one part of the country, advocacy around improved access to malaria services in prisons and pre-trial detention should not be limited to areas with malaria.

Monitoring of policies and budgets for addressing malaria in pre-trial detention and prisons should be an explicit part of the community-based monitoring of malaria policies and budgets described above. As above, it should also include support for pushing for accountability in these areas. In a similar way, the legal literacy training for prisoners described in the TB section above should also include attention to human rights relating to malaria. These activities have not been included in the table under this section to avoid repetition.

Support to Implementation Capacity

Across all of the program areas, there is a need to build in-country capacity to ensure that the proposed human rights interventions can be implemented at the recommended scale.

A few organizations have, to date, been very central in the capacity-building of different stakeholders, especially around HIV, TB, human rights and the law, but they will not have the capacity to do this as work is scaled up. It is critical that there be investment in having these expert organizations train other civil society organizations to be able to carry out this training (as well as other functions such as monitoring implementation of laws, regulations and policies). The newly-trained organizations will likely require sustained support and capacity building as they grow into this new role.

This will require upfront investment in human rights and gender equality capacity-building that will slow the roll-out process of recommended activities, but it is absolutely critical for attaining the large-scale coverage that is needed at an appropriate quality. This should be built into the budget and timeframe for all of these activities.

A variety of stakeholders noted that current funding streams are not reaching down to the grassroots, with a detrimental impact on program quality, uptake and impact. It can be a challenge to work with grassroots organizations – both from a coordination perspective and recognizing the capacity-building that may be required – but it is critical that communities trust implementers, and this is often best done by community engagement in the implementation.

Monitoring Impact of Comprehensive Programs to Remove Human Rights-Related Barriers Across Program Areas

This baseline assessment is designed as the first step in a process that will include mid-term and end-term assessments during the current 2017-2022 Strategy of the Global Fund. Baseline values will be provided for the indicators recommended to be assessed in each of two assessments at midline and endline.

Due to the broad range of barriers, key and vulnerable populations, and recommended programs and interventions, a corresponding range of indicators and data collection methods will be needed, including quantitative, qualitative and policy assessments, with a focus on the lived experience of key and vulnerable populations. Whereas some of the outputs to the recommended programs/interventions can be measured in numerical terms, many of the real changes in human rights-related barriers to access to services will need to be measured in qualitative terms, examining and learning from the experiences of key and vulnerable populations. In the longer term, changes to the legal environment and the testing and treatment cascades for HIV and TB will also need to be examined and learned from.

(a) Qualitative Assessment

Each assessment should repeat the major steps of this baseline assessment, including, but not limited to, desk review, key informant interviews and focus group discussions with key and vulnerable populations and other relevant stakeholders and community members in relation to both HIV and TB:

- The desk reviews should focus on identifying any new research or innovative interventions on HIV-, TB- and/or malaria-related barriers in Kenya and evaluations of any programs to reduce these barriers, including those considered for or implemented as part of the comprehensive rights-based approach.
- Key informant interviews and focus group discussions should focus on changes in the programmatic, social, political and legal environment since this baseline assessment, as well as capture diverse views from new interview participants on how the comprehensive approach is being implemented, looking for strengths and weaknesses. It is important to note that there may be people in the new focus groups who were not previously interviewed and have more general experiences and insights beyond recent project changes.
- Focus group discussions with key populations and other stakeholders may consider the following:

(i) *Specific questions: HIV*

- Is it now easier to access HIV services than two years ago? Why?
- Are these changes the same for all key populations? Are there gender-related differences?
- Has general knowledge about HIV changed?
- How have stigma and discrimination related to HIV changed?
- Do health care workers generally respect confidentiality related to HIV?
- How are people living with HIV treated by police or prison officers? Has this changed in the last two years?
- Is it easier to access HIV-related legal services than two years ago? If so, how? Are these services better equipped to deal with HIV-related cases?
- Have there been any changes in the types of court judgments in relation to HIV in the last two years? If so, what type of changes?
- Do people know more about how human rights are relevant to HIV than two years ago? If so, where have people got this information?
- To what extent are affected populations involved in policy development and service provision and monitoring of their implementation? How has this changed in the last two years?
- Have HIV services in detention settings changed over the last two years? If so, in what ways?
- (Showing the comprehensive approach) Have you been reached by or accessed any of these services? How useful were they?

(ii) Specific questions: TB

- Is it now easier to access TB services than two years ago? Why?
- Are these changes the same for all key populations? Are there gender-related differences?
- Are TB services better connected to HIV services (e.g. testing)? If so, how?
- Has general knowledge about TB changed?
- Have stigma and discrimination related to TB changed?
- Is it easier to access TB-related legal services than two years ago? If so, how are these services better equipped to deal with TB-related cases?
- Have TB services in detention settings changed over the last two years? If so, in what ways?
- (Showing the comprehensive approach) Have you been reached by or accessed any of these services? How useful were they?

(iii) Specific questions: Malaria

- Is it now easier to access malaria services than two years ago? Why?
- Are these changes the same for women and men? If not, why not?
- Are these changes the same across all at risk and underserved groups?
- How has the engagement of affected population in the malaria response changed in the last two years?
- Have there been any changes in community systems for participating in malaria programs? If so, what has changed and why do you think this is?
- Has access to malaria services for refugees changed in the last two years? If so, in what ways?
- Has access to malaria services for people living with HIV changed in the last two years? If so, in what ways?
- Has access to malaria services for prisoners changed in the last two years? If so, in what ways?
- (Showing the comprehensive approach) Have you been reached by or accessed any of these services? How useful were they?

(iv) Specific questions: related experiences of key and vulnerable populations

- Has stigma and discrimination related to your key or vulnerable population changed?
- Have health worker attitudes and treatment toward your population changed?
- Have police attitudes and treatment of your population changed?
- Have media portrayals of your population changed?
- Has the legal environment impacting your population changed?
- Have community attitudes toward your population changed?
- Has your population's awareness about their rights changed?
- Is it easier for your population to access HIV/TB/malaria services? If so, how?
- Is it easier for your population to report violations of human rights? If so, how?
- Is it easier for your population to access and use health services? If so, how?

(b) Quantitative Assessment

The appropriate mix of quantitative indicators to assess implementation of the comprehensive package of services to address human rights barriers to accessing HIV, TB and malaria services can only be determined once the final package of services is agreed. Subject to revision once this package has been agreed, below are some illustrative indicators that might be useful to assess progress comprehensive services based on the programs/interventions:

- Number and profiles (age, sex, region, etc.) of individuals reached through awareness-raising among the general public
- Number of religious, community, county leaders, teachers and parents who have received legal literacy training
- Number and proportion of graduates from medical, nursing, and other relevant professional schools and programs who have been trained in HIV, TB, and human rights and medical ethics
- Number and proportion of graduate from the police and prison training institutions who have been trained in HIV, TB and human rights
- Number of practicing health care workers, police, prison officers, judges, magistrates and legal researchers who have been trained on HIV, TB, and human rights, including communicating with key populations and stigma reduction
- Average exam score for HIV- and TB-related human rights content in pre-service training (disaggregated by health professionals, police, prison officers)
- Number of certified paralegals whose training included HIV, TB and human rights
- Number of cases successfully resolved through ADR
- Number and outcomes of HIV- or TB-related court cases supported through trained *pro bono* lawyers
- Number of community health volunteers trained in CCMM, gender and human rights
- Number of counties with an active multi-sectoral technical working group on malaria (at least two meetings in the previous 12 months)
- Number (percentage) of people living with HIV who know their status, disaggregated by gender and key population to the extent possible
- Number (percentage) of people who are testing for HIV and TB, disaggregated by gender and key population to the extent possible
- Number (percentage) of people living with HIV who are on ART, disaggregated by gender and key population to the extent possible
- Number (percentage) of people with TB who have been linked with treatment, disaggregated by gender and key population to the extent possible
- Number (percentage) of people who are lost to follow up receiving HIV services, disaggregated by gender and key population to the extent possible

- Number (percentage) of people who are lost to follow up receiving TB treatment, disaggregated by gender and key population to the extent possible
- Number (percentage) of people on antiretroviral therapy who are virally suppressed disaggregated by gender and key population to the extent possible
- Number of correctional facilities that offer harm reduction services
- Number of correctional facilities that report no stockouts of malaria test-kits and drugs in the previous six months
- Number of LLINs distributed in refugee camps
- Proportion of county health budget allocated to malaria
- Proportion of county health budget allocated to human rights programming relevant to HIV, TB or malaria
- Community scorecard results and their change over time
- Number of peer human rights educators who have been trained in conducting legal empowerment, including in human rights (disaggregated by population)
- Number and estimated proportion of individuals from key populations trained in legal literacy
- Number of complaints/cases filed (including but not only to HAT) involving key populations and/or HIV and/or TB related; numbers of these complaints/cases resolved (in timely manner, to be determined); details of cases addressed at devolved level should be recorded if this devolution occurs
- Number of cases relating to discrimination against women in the context of HIV resolved through alternative dispute resolution
- Outcomes of targeted advocacy campaigns (e.g. prison sentencing policy, prison infrastructure improvements, community health worker ability to provide rapid diagnostic testing for malaria and treatment for simple malaria)
- Stigma Index scores

(c) Policy Assessment

Each assessment should include a systematic review and evaluation of relevant laws and policies to capture how the legal and policy environment evolves over the intervention period. In addition to assessing the existence and content of laws and policies, it will also be important to collect programmatic and financial / economic data, where available, on implementation including, for example, budget allocation to human rights-relevant activities, expenditure of this budget, and creation/use of any structures to address or monitor human rights barriers to accessing HIV, TB or malaria services. This will all require a mixture of desk review and in-country data collection. New policy recommendations based on interventions above should be evaluated on their technical and political viability; where considered viable, indicators should be included to track progress over time toward policy change.

11. Conclusion

Key and vulnerable populations in Kenya continue to face a range of human rights-related barriers to accessing and using HIV, TB and malaria services. During data collection for this assessment, a range of in-country stakeholders affirmed the continued challenges posed by stigma and discrimination, punitive laws, policies and practices, availability and accessibility of services, gender-related barriers and underlying poverty. These play out differently in different parts of the country, for different populations and even across each of the diseases studied. The implication is that the programmatic response must be very carefully tailored to account for this.

A lot of programming has already been implemented under all of the identified program areas for overcoming these human rights barriers to accessing services. However, many of them have been fragmented and/or small scale. There is an important opportunity to consolidate efforts and effectively scale-up programs that have been effective in addressing barriers and introduce additional programs to fill existing gaps. There are many implementing organizations in Kenya, each with capacity in different areas. Community empowerment should be front and centre of all of these plans. In this context, understanding the strengths and capacity of the different stakeholders and capitalizing upon this will lead to the most efficient national response, despite the administrative burden of coordination that it will impose. There is a synergy in activities proposed across program areas that can promote efficiency in the response, but capacity strengthening at all levels will be critical to success in any of the program areas for each disease.

Ensuring a comprehensive human rights-based response to existing barriers to HIV, TB and malaria services will thus require a combination of scaling up existing efforts (e.g. peer support networks, community health volunteers and paralegal programs) as well as investing in new programs (e.g. psychosocial support to survivors of GBV). Both will require substantial capacity-building and resource commitments to ensure that programs are able to achieve their necessary reach in each county and throughout Kenya, and ultimately that organizations engaged in delivering these services will have the support necessary to be able to sustain their efforts.

12. Annexes

Annex 1: International Human Rights Commitments Relating to HIV, TB and Malaria

LEGISLATION/ STATUTE/CODE/ CONVENTION/ PROTOCOL	SPECIFIC ARTICLE/ PROVISION	CONTENT OF ARTICLE/PROVISION	HIV, TB AND MALARIA-RELATED IMPLICATIONS
International Covenant on Civil and Political Rights (UN, 1966)	Article 6(1)	Right to life	This includes the right to access to life saving drugs and other services which are necessary to sustain life. The right to life is threatened when such services are denied. (KELIN, 2018i)
International Covenant on Economic, Social and Cultural Rights (ICESCR)	Article 12(1)	Right to the highest attainable standard of health	Every person has the right to the highest attainable standard of health. This puts an obligation on state parties to ensure the “availability, acceptability, accessibility and quality of diagnostics and treatment”. (KELIN, 2018i)
International Covenant on Civil and Political Rights (UN, 1966)	Article 26	Rights to non-discrimination and equality	The right to equality and non-discrimination plays an essential role in ensuring that people with HIV, TB or malaria enjoy the same rights and protections as others. These rights are said to protect people “in both public and private settings, including but not limited to, health care, employment, education and access to social services”. It also substantially contributes to removing other barriers to access to health services such as stigma and discrimination. (KELIN, 2018i) (WHO, 2001).
Convention on the Rights of the People with disabilities (UN, 2007)	Article 5(1)		
Convention on the Elimination of all forms of Racial Discrimination (UN, 1965)	Article 5(e)(4)		
International Covenant on Civil and Political Rights (UN, 1966)	Article 17(1)	Right to privacy	The right to privacy plays an important role in ensuring people’s participation in their treatment process. Ensuring a person’s privacy from “unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honor and reputation” is closely connected to healthy behavior. ((UN, 1966; WHO, 2010) Further, it is important to note that the right to privacy encapsulates protection from mandatory testing, which would also constitute a violation of other rights such as rights to choose and to participate meaningfully in their treatment. It has been stated by WHO that “individuals have a right to privacy that protects them against both mandatory testing and

LEGISLATION/ STATUTE/CODE/ CONVENTION/ PROTOCOL	SPECIFIC ARTICLE/ PROVISION	CONTENT OF ARTICLE/PROVISION	HIV, TB AND MALARIA-RELATED IMPLICATIONS
			<p>disclosure of their health status” (WHO, 2001).</p> <p>In the case of TB, and all contagious diseases a delicate balance needs to be maintained between public safety and privacy of an individual. (KELIN, 2018i)</p>
Convention against Torture and other Cruel, Inhumane or Degrading Treatment or Punishment (UN, 1984a)	Article 16(1)	Rights to be free from cruel, inhuman and degrading treatment.	Necessary medical treatment cannot generally be regarded as inhuman or degrading, and medical need must be convincingly demonstrated.
International Covenant on Civil and Political Rights (UN, 1966).	Article 7		Protection of people who are detained in hospitals or other detention centers due to their real or perceived TB status is necessary. This includes the right to be free of substandard conditions and to have equivalent health care. Protection also includes availability of clean and sanitary conditions. (KELIN, 2018i)
International Covenant on Civil and Political Rights (UN, 1966).	Article 19(2)	Right to seek, receive and impart information	<p>The right to information requires meaningful participation by the patient in his or her disease treatment process and preventive measures (WHO, 2010)</p> <p>Misinformation among the public on causes and transmission can lead to stigma and discrimination for people living with HIV or TB (WHO, 2001).</p>
International Covenant on Civil and Political Rights (UN, 1966) and the Siracusa Principles (UN, 1984b).	Article 9(1)	Freedom from arbitrary arrest and detention.	<p>Members of key populations often face arbitrary arrest and detention, which constitutes a major human rights-related barrier.</p> <p>WHO Guidance states that such detention for health purposes (e.g. TB) should never be routine and should only be done as the last resort for example in cases where a person is contagious, refuses treatment and refuses to undergo assessment of his or her level of infection. For a patient undergoing treatment, no detention is necessary (WHO, 2010).</p>

LEGISLATION/ STATUTE/CODE/ CONVENTION/ PROTOCOL	SPECIFIC ARTICLE/ PROVISION	CONTENT OF ARTICLE/PROVISION	HIV, TB AND MALARIA-RELATED IMPLICATIONS
International Covenant on Civil and Political Rights (UN, 1966)	Article 7	Right to informed consent	The ethical necessity of receiving informed consent from the patient before testing or treating him or her ensures their participation and gives them an opportunity to decide for themselves. In the absence of consent, the patient should be counselled and made aware of the risks (WHO, 2010).

Annex 2: Protective Laws for Specific Relevant Populations in the Context of HIV

LEGISLATION /STATUTE/ CODE	SPECIFIC ARTICLE/ PROVISION	CONTENT OF ARTICLE/PROVISION	HIV-RELATED IMPLICATIONS
Sexual Offences Act, 2006	Section 19	This Section prohibits prostitution of person with mental disabilities.	These provisions seek to protect persons with mental disabilities preventing their exposure to prostitution and consequently HIV and other health issues.
Sexual Offences Act, 2006	Section 14	Prohibits child sex tourism	These provisions seek to protect children from sexual exploitation, forceful engagement in prostitution and pornography.
Sexual Offences Act, 2006	Section 15	Prohibits child prostitution	
Sexual Offences Act, 2006	Section 16	Prohibits child pornography	
The Children Act, 2001	Section 15	Protection from sexual exploitation “A child shall be protected from sexual exploitation and use in prostitution, inducement or coercion to engage in any sexual activity, and exposure to obscene materials”	
Children Act, 2001	Sections 3, 4, 5 & 9.	These sections seek to ensure progressive realization of the rights of child, always keeping the best interest as a prime consideration, non-discrimination and right to health care.	Ensuring equal rights and protection of children enforces the rights stated under the Constitution. Principles of non-discrimination and protection from abuse helps to ensure children who are living with HIV are able to access health services without facing barriers. It has been proved that “stigma-related experiences like social rejection, discrimination, and physical violence increase the risk for psychological problems among HIV-infected individuals, which may also hamper treatment behaviors.” (McHenry et al., 2017)
Children Act, 2001	Sections 12, 13, 15 & 19.	These provisions seek to ensure the rights of disabled children to dignity, appropriate medical care and special care; protection from abuse and any other form of exploitation; protection from sexual exploitation; privacy.	
Children Act, 2001	Section 14	Protection of a child from harmful cultural practices such as female genital cutting, early marriage or anything else that can affect the child.	Kenya has committed to ending child marriage by the end of 2020 (UNESCO, 2013). This provision specifically provides for protection of children from early marriage when such a practice can affect the child. (Girls Not Brides, 2018b) It is well established that child brides face challenges negotiating safe sex, avoiding early pregnancy or accessing health services including for SRH and HIV. (Girls Not Brides, 2018a)
Matrimonial Property Act, 2013.	Section 4, 13	These Sections give equal rights to matrimonial property to both spouses.	Equal rights to matrimonial property helps women to be financially independent of their male counterparts and can prevent them from engaging in risky professions such as sex work. (Human Rights Watch, 2003)
The Marriage Act, 2014	Section 4	This Section sets the minimum age of marriage as 18 with no exceptions.	Despite the strict laws, child marriage remains prevalent in Kenya. (Girls Not Brides, 2018b)

LEGISLATION /STATUTE/ CODE	SPECIFIC ARTICLE/ PROVISION	CONTENT OF ARTICLE/PROVISION	HIV-RELATED IMPLICATIONS
The Marriage Act, 2014	Section 45 (3a), (3b) & (3c).	Even if a marriage is completed as per customary law, it should be between parties who are at least 18 years old, between person who are not prohibited to marry, and through free consent of the parties.	The law prioritizes age of marriage and consent as over culture or tradition, thereby nullifying any forced marriage of an underage girl.
Pharmacy and Poisons Act, 1989	Section 29	It prohibits the sale of poisons (drugs) except on a prescription by a medical practitioner, veterinarian or dentist.	Sale of drugs on prescription avoids misuse and helps to curb misuse. However, this law can be misapplied to deny sale of clean needles/syringes, leading to a failure of harm reduction efforts. (Mainline, 2015)
Pharmacy and Poisons Act, 1989- Pharmacy and Poisons (Registration Of Drugs) Rules	Rule 6	In order to register a new drug, its safety, efficacy, quality and economic value shall be ensured by the Board.	Any new drug, if it meets the criteria under this section, can be registered and be used for treatment. The act makes this process faster and more effective. The act also establishes the Pharmacy and Poisons Board which oversees the registration of pharmacies and new drugs.

Annex 3: Laws that Create Barriers for Men Who Have Sex with Men in the Context of HIV

LEGISLATION/ STATUTE/CODE	SPECIFIC ARTICLE/ PROVISION	CONTENT OF ARTICLE/PROVISION	HIV-RELATED IMPLICATIONS
Penal Code	Section 162	<p>This section penalizes any person who “has carnal knowledge against the order of nature”, “has carnal knowledge of an animal”, “permits a male person to have carnal knowledge of him or her against the order of nature”.</p> <p>These actions are considered a felony and are punishable for up to 14 years in prison. The punishment increases to 21 years, if the “offence was committed without the consent of the person who was carnally known” or if the consent was obtained by threat or intimidation.</p>	Criminalization of sex between men restricts the access of men who have sex with men to health services and increases the stigma against them. (Kenya Human Rights Commission, 2017)
Penal Code	Section 163	This section punishes any person who attempts to carry out any activity stated under Section 162.	
Penal Code	Section 165	<p>This Section punishes acts of “gross indecency with another male” or if someone “procures another male person to commit any act of gross indecency with him” or “attempts to procure the commission of any such act by male person”.</p> <p>Any action under this section is a felony punishable by 5 years.</p>	This provision has previously allowed law enforcement officials to engage in forced anal testing. As recently as 2016, it still created barriers to access to health and legal services for MSM as they feared persecution and harassment. (Human Rights Watch, 2015) (Human Rights Watch, 2016)

Annex 4: Laws that Create Barriers for People Who Use Drugs in the Context of HIV

LEGISLATION/ STATUTE/CODE	SPECIFIC ARTICLE/ PROVISION	CONTENT OF ARTICLE/PROVISION	HIV-RELATED IMPLICATIONS
Kenya Narcotic Drugs and Psychotropic Substances (Control) Act, 1994	Section 3	This provision seeks to punish the possession of narcotic drugs including cannabis.	Punitive approaches to drugs increase the likelihood of drug users contracting HIV and hepatitis (Mainline, 2015).
Kenya Narcotic Drugs and Psychotropic Substances (Control) Act, 1994	Section 4	Punishes trafficking of narcotic drugs.	
Kenya Narcotic Drugs and Psychotropic Substances (Control) Act, 1994	Section 5	This Section seeks to punish any person who is a user of drugs or is present or has in his possession any utensil/pipe used for injecting or smoking.	<p>This law has been used to prosecute health care workers and outreach workers and constitutes a barrier to needle exchange programs (KELIN, 2014b).</p> <p>It runs contrary to Article 38 of the 1961 United Nations Convention on Narcotic Drugs, which recognizes drug use as “health condition deserving measures of treatment, education, after-care, rehabilitation and social reintegration.” (Mainline, 2015).</p>

Annex 5: Laws that Create Barriers for People Who Engage in Sex Work in the Context of HIV

LEGISLATION/ STATUTE/ CODE	SPECIFIC ARTICLE/ PROVISION	CONTENT OF ARTICLE/PROVISION	HIV-RELATED IMPLICATIONS
Penal Code	Section 151	This section criminalizes detention of a person for immoral purpose.	<p>These provisions seek to punish those who are living on the earnings of someone who engages in sex work. This usually includes their families and friends. One implication is that, due to the fear of harassment of their families and friends, people who engage in sex work do not reach out to health care workers or hospitals for health related issues. (Kenya Human Rights Commission, 2017)</p> <p>This fear of prosecution and that they would be outed as people who engage in sex work and turned over to the police creates a barrier to accessing health and legal services (NSWP, 2017).</p>
Penal Code	Section 153	It criminalizes being a male person living on the earnings of a prostitute. A male is guilty of felony when he “knowingly lives wholly or in part on the earnings of prostitution” or “persistently solicits or importunes for immoral purpose”. This section also punishes “aiding, abetting or compelling” and someone who helps to engage in prostitution or cohabits, exercises control or influence over such a prostitute.	
Penal Code	Section 154	Women living on the earnings of prostitution.	
Penal Code	Section 155	Premises used for prostitution	
Penal Code	Section 156	Keeping or managing a brothel	
Penal Code	Section 182	A person can be charged with a misdemeanor when a “common prostitute” behaves in a “disorderly or indecent manner in a public place”. It also criminalizes any person “who solicits for immoral purpose”.	<p>This provision is extremely broad. The Code fails to define a prostitute, which leaves room for interpretation by local law enforcement officers (FIDA Kenya, 2008).</p> <p>This law as written means that female, male or transgender sex workers can be charged under it (Human Rights Watch, 2015). Transgender people are often targeted by Kenyan officials on the grounds stated under this section along with section 153 and 154 of the Penal Code. The law is used by law enforcement to arrest and detain transgender people who engage in sex work because they are stigmatized and assumed to engage in illegal activities (Human Rights Watch, 2015).</p>
Sexual Offences Act, 2006	Section 17	This Section criminalizes exploitation of a prostitute. A person is guilty under this provision when he/she “causes or incites another person to become a prostitute” or when such a person “controls any of the activity related to prostitution”.	This legislation also fails to define the term ‘prostitute’. Although this section does not criminalize sex work, it seeks to punish those who incite a person into sex work or control the activities of sex workers. It adds to the exiting rhetoric and ambiguous law (FIDA Kenya, 2008).
Mombasa Nuisance General bylaws, 2003.	Section 258(m) and 258(n)	Prohibits sex work between consenting adults. It prohibits the following acts- “(m) Loiter or importune for the purpose of prostitution (n) Procure or attempt to procure a female or male for the purpose of prostitution or homosexuality ... shall be guilty of an offence.”	<p>Criminalization of sex work drives sex workers underground, preventing them from seeing a health care worker and accessing services (Naomi Van Stapele & Lorraine Nencel, 2016).</p> <p>Although national laws do not criminalize sex work, some county laws do, which creates a barrier even as national laws are supposed to take precedence over county (WOTRO Science for Global Development in The Hague, 2016) (Naomi Van Stapele & Lorraine Nencel, 2016).</p>
Nairobi Nuisance General bylaws, 2007.	Section 19(m)	It prohibits “any person who in any street – loiters or importunes for purposes of prostitution is guilty of an offence.”	

LEGISLATION/ STATUTE/ CODE	SPECIFIC ARTICLE/ PROVISION	CONTENT OF ARTICLE/PROVISION	HIV-RELATED IMPLICATIONS
Kisumu Municipal Council bylaws, 2007.	Part VIII	It mandates punishment for anyone who- “(m) molest, solicit or importune any person for the purposes of prostitution or loiter on any street or public place for such purposes; or (n) willfully and indecently expose his person in view of any street or public place”	Law enforcement officers arrest female and male sex workers under these local laws (WOTRO Science for Global Development in The Hague, 2016) (Naomi Van Stapele & Lorraine Nencel, 2016).

Annex 6: Laws that Create Barriers for Women/Girls in the Context of HIV

LEGISLATION/ STATUTE/ CODE	SPECIFIC ARTICLE/ PROVISION	CONTENT OF ARTICLE/PROVISION	HIV-RELATED IMPLICATIONS
The Marriage Act, 2014	Section 6(3)	A marriage, if governed by tradition or between persons of Islamic faith can be polygamous.	Studies have shown that having multiple concurrent sexual partners cohabiting constitutes a risk factor for HIV (Reniers & Watkins, 2010).

Annex 7: Protective laws relevant to HIV

LEGISLATION/ STATUTE/ CODE	SPECIFIC ARTICLE/ PROVISION	CONTENT OF ARTICLE/PROVISION	HIV-RELATED IMPLICATIONS
HIV and AIDS Prevention and Control Act, 2006	Section 14, 22	These Sections ensure consent to testing and disclosure of HIV status, as well as privacy related to test results for people living with HIV.	Confidentiality and privacy are essential. When a health care worker reveals a person's HIV status without his or her consent, it is a clear breach of privacy. An association exists between breaches of the right to privacy and stigma and gender-based violence. (KELIN, 2014d)
The HIV and AIDS Prevention and Control Act, 2006	Section 4, 5, 6, 7 & 8.	Provision of HIV & AIDS information and education through public campaigns, by healthcare service providers, at workplace and institutions of learning.	HIV and AIDS education and information are key to prevention and control.
The HIV and AIDS Prevention and Control Act, 2006	Section 13	Prohibition against compulsory testing and HIV test as a precondition for employment, marriage, admission, travel, access to health services and insurance cover.	These provisions seek to prevent forced HIV testing and ensure that informed consent is required for HIV testing.
The HIV and AIDS Prevention and Control Act, 2006	Section 14	Informed consent to HIV testing.	
The HIV and AIDS Prevention and Control Act, 2006	Section 15, 16, 17 & 19.	Availability of testing centers and counseling and access to healthcare services. These provisions mandate making testing centers available for safe HIV testing with pre- and post-test counseling services.	Counseling is a cornerstone of the HIV response. It provides useful information and can be an entry point into appropriate prevention, care and treatment services. It also helps to prevent misinformation and stigma around HIV. Access to safe HIV testing and healthcare services is important for everyone, and particularly relevant to those belonging to marginalized populations.
The HIV and AIDS Prevention and Control Act, 2006	Section 18, 20-23	These provisions of law seek to protect the confidentiality and privacy of a person's test results, HIV status and medical records. Any breach of these protective provisions is stated to be an offence.	Confidentiality and privacy are essential.
The HIV and AIDS Prevention and Control Act, 2006	Section 25-30.	Establishment and the procedure of the HIV & AIDS Tribunal.	The HIV & AIDS Tribunal has been established to improve the access to courts and litigation for matters involving people living with HIV and their family members. The tribunal has the jurisdiction to adjudicate on matters stated under this act. It aims to resolve disputes involving forced testing, discrimination, and denial of access to health and other services. The tribunal aims to overcome challenges faced by key populations accessing the courts and consequently justice.
The HIV and AIDS Prevention and Control Act, 2006	Sections 31-38	Prohibition on discrimination in workplace, schools, traveling and habitation, public service, insurance services, health institutions and for burial.	These provisions mandate a penalty on anyone who engages in discriminatory behavior against people living with HIV.

Annex 8: Laws Criminalizing HIV Transmission and Non-disclosure that Create Barriers to Accessing Services

LEGISLATION/ STATUTE/CODE	SPECIFIC ARTICLE/ PROVISION	CONTENT OF ARTICLE/PROVISION	HIV-RELATED IMPLICATIONS
Sexual Offences Act, 2006	Section 26(1)	<p>Section 26 criminalizes the transmission of HIV and other STDs.</p> <p>Any person who knows of his or her HIV status, does the following knowingly-</p> <ol style="list-style-type: none"> i. Will infect another person with HIV or other life threatening STD. ii. Is likely to infect another person with HIV or other life threatening STD. iii. Will infect another person with an STD. <p>This provision applies to married couples as well.</p> <p>If a person is found to be guilty under this provision then he or she can be imprisoned for 15 years, which can be extended to a life term.</p>	<p>The implications and extent of this provision are broad since any person who has put the other at risk of contracting the virus can be prosecuted, irrespective of whether or not transmission occurred. Even a married person can be prosecuted for engaging in sexual activity with his or her own spouse (KELIN, 2014b).</p> <p>There exists no evidence to prove that such laws curb HIV transmission. Rather, they push people away from seeking HIV testing and treatment services. They also contribute to the stigma and discrimination surrounding a person's HIV status (KELIN, 2018c).</p>
Sexual Offences Act, 2006	Section 26(2)	<p>When a person is accused of having committed the offence under Section 26(1), a Court can direct samples to be taken to ascertain the accused person's HIV status.</p>	<p>The constitutionality of this Section has been challenged before the High Court of Kenya in Nairobi (KELIN, 2018c).</p>
Sexual Offences Act, 2006	Section 26(7)	<p>This provision prohibits any claim against the state, any minister or a medical practitioner in a court of law by any aggrieved person who was prosecuted under Section 26.</p>	<p>This Sub-Section effectively protects the State, all ministers and medical practitioners from any liability for wrongful prosecution or harassment of people living with HIV or other people (KELIN, 2014b).</p>
Sexual Offences Act, 2006	Section 43(3)(c)	<p>This provision confirms that one engages in an intentional and unlawful act if the act is committed under false pretenses or by fraudulent means, which includes intentionally failing to disclose to the person in respect of whom an act is being committed, that they are infected by HIV or any other life threatening sexually transmittable disease.</p>	<p>This provision criminalizes the non-disclosure of HIV status, despite constitutional protections and jurisprudence.</p> <p>This law has not yet been challenged before a court of law.</p>

Annex 9: Protective National Laws Relevant for TB for Key Populations

LEGISLATION/ STATUTE/ CODE	SPECIFIC ARTICLE/ PROVISION	CONTENT OF ARTICLE/PROVISION	TB-RELATED IMPLICATIONS
The Persons Deprived of Liberty Act, 2016	Section 15	It provides for treatment, medical examination and preventive healthcare for inmates and people in custody.	The Persons Deprived of Liberty Act, 2016 was enacted to give teeth to Articles 29(f) and 51 of the Constitution. Article 27(f) seeks to ensure freedom and security for every person, including the right to be free from cruel and unlawful punishment. Article 51 seeks to ensure rights of persons who have been imprisoned or in custody. Although the act provides for confidentiality of information, the disclosure guidelines are a little unclear, leaving room for misuse by the state. (KELIN, 2018i)
The Persons Deprived of Liberty Act, 2016	Section 16	It provides for confidentiality of medical records of persons in custody. Disclosure is allowed for effective prevention of communicable diseases	

Annex 10: Laws Relevant to TB that Might Constitute Barriers for Key Populations

LEGISLATION/ STATUTE/CODE	SPECIFIC ARTICLE/ PROVISION	CONTENT OF ARTICLE/PROVISION	IMPLICATION TO TB PREVENTION and TREATMENT
The Public Health Act, 1921	Section 17	Declares TB an infectious disease.	<p>These provisions have been used to discriminate against people living with TB. Prior to 2015, there were reported cases of incarceration for people living with TB for seven to eight months for failing to complete their treatment or for other similar reasons. This also exposed other prison inmates to such infection.</p> <p>While, some of these provisions may be necessary for maintaining public health, lack of clear guidelines leaves them open to misuse resulting in a serious breach of privacy, confidentiality and consent.</p> <p>Moreover, these provisions increase the stigma surrounding TB. Due to lack of information and knowledge, TB is sometimes considered as non-treatable and those living with TB are marginalized by society. Additionally, lack of information has affected people living with TB. There have been reports where people living with TB have failed to complete the course of treatment since they stopped taking their medication as soon as they started feeling better.</p>
The Public Health Act, 1921	Section 18	Criminalizes non-reporting of a person who is infected with TB. This obligation is on the family members, medical practitioners or any other person who is aware of the condition.	
The Public Health Act, 1921	Section 27	Gives power to the medical officer of health to remove any person and confine him in isolation by an order of a Magistrate. Such a person can be confined until the medical officer of health is convinced that he is infection free.	
The Public Health Act, 1921	Section 28	This provision criminalizes wilful exposure of disease to the public, making someone else expose the infection to the public or providing bedding or clothing known to have been exposed to such an infection. It also makes it unlawful to enter public premises without notifying the owner of such an infection and such person may be required to pay for disinfection.	

Annex 11: Laws Relevant to Malaria

LEGISLATION/ STATUTE/CODE	SPECIFIC ARTICLE/ PROVISION	CONTENT OF ARTICLE/PROVISION	IMPLICATION TO MALARIA PREVENTION & TREATMENT
Public Health Act, 1986	Section 168A	This provision gives the power to the Municipal Councils, with the approval of the Minister of Health, to make bylaws for preventing and abating conditions permitting or favouring the breeding of mosquitoes and flies and, generally, for the prevention of malaria and other insect borne diseases.	This is important and can be strong measures to promote an environment that is not conducive to mosquitos breeding. There is no evidence of implementation of fines in this context.
Public Health Act, 1986	Section 136-143	These provisions declare all breeding places of mosquitoes such as stagnant water, sewage, rubbish, etc. to be a nuisance. Fines may be imposed on property owners where mosquito breeding is likely or already occurring.	
The Malaria Prevention Act, 1983	Section 3, 5, 6, 7 & 13	The act aims to lay down the prevention strategies such as- <ol style="list-style-type: none"> 1. Formation and maintenance of drainage systems (Section 3); 2. Ensuring the flow of water without any obstruction (Section 5 & 6); 3. Construction of drains (Section 7) and; 4. Penalty of 1000 shillings for people not carrying out their obligations under this act (Section 13). 	Prevention of breeding has been shown to be an effective strategy to prevent malaria. These are protective laws which aim to prevent and deter people from engaging in unhealthy practices. There is no evidence of implementation of fines in this context.

Annex 12: List of organizations participating in key informant interviews, focus group discussions and provision of programmatic information

Key Informant Organizations

Organization
Afya Pwani
AHF
AMREF
BHESP- Bar Hostess Empowerment and Support Program
BLAST-Building Lives Around Sound Transformation
CHEC- Coast Hostess Empowering Community
CHS
COFAS Community Forum for Advanced and Sustainable Development
COSWA- Coast Smart Women against HIV/AIDS & STI's
County Health Departments
County Tuberculosis, Leprosy and Lung Disease Program
Court Users Committee
DANIDA
EGPAF- Elizabeth Glaser Pediatric AIDS Foundation
HAPA Kenya-HIV and AIDS People Alliance of Kenya
Healthstrat
HIV and AIDS Tribunal
ICWK – International Community of Women living with HIV, Kenya
ILO- International Labour Organisation
INERELA- International Network of Religious Leaders Living with or Personally Affected by HIV and AIDS
Ishtar
KASCO Kisumu County
KELIN - Kenya Legal & Ethical Issues Network on HIV and AIDS
KeNAAM- Kenya NGO Alliance Against Malaria
KENEPOTE- Kenya Network of HIV Positive Teachers
Kenya Police Service
Kenya Prison Service
Kenya Red Cross
KESWA–Kenya Sex Workers Alliance
KNCHR- Kenya National Commission on Human Rights
KP consortium
LINKAGES
LVCT
MAAYGO- Men Against AIDS Youth Group
MEWA
Minority Rights Group

Organization
MOH- Ministry of Health
NACC - National AIDS Control Council
NASCOP- National HIV/AIDS and STD Control Program
National Gender and Equality Commission (NGEC)
NEPHAK-National Empowerment Network of People living with HIV/AIDS in Kenya
NMCP – National Malaria Control Program
NYARWEK
OSIEA – Open Society Institute East Africa
PEMA Kenya
PEPFAR
PMI – President’s Malaria Initiative
PS Kenya
PUMMA
Reachout
SCOPE
StopTB
SUPKEM-Supreme Council of Kenya Muslims
SWAP- Safe Water and AIDs Project
Talaku TB
UNAIDS- Joint United Nations Program on HIV/AIDS
UNDP- United Nations Development Program
USAID
Victory Post-test Club
WFP- World Food Program
WOFK- Women Fighting AIDS in Kenya

Focus group discussions (by location)

Nairobi

1. Focus group discussion with TB survivors
2. Focus group discussion with transgender people
3. Focus group discussion with young women
4. Focus group discussion with elderly women living with HIV

Mombasa

1. Focus group discussion with people living with HIV
2. Focus group discussion with people who inject drugs
3. Focus group discussion with females who engage in sex work
4. Focus group discussion with people who inject drugs

5. Focus group discussion with men who have sex with men

Kisumu

1. Focus group discussion with adolescent girls
2. Focus group discussion healthcare workers
3. Focus group discussion mothers of children under five
4. Focus group discussion people with disabilities

Kitui

1. Focus group discussion with TB champions
2. Focus group discussion with people living with HIV (women and men)
3. Focus group discussion with people living with HIV (adolescent and young people)
4. Focus group discussion with men who have sex with men
5. Focus group discussion with females who engage in sex work

Annex 13: Documents Reviewed for the Desk Review

1. African Commission on Human & Peoples' Rights. (2018). HIV, The Law and Human Rights In The African Human Rights System: Key Challenges and Opportunities for Rights-Based Responses. Retrieved from https://www.unaids.org/sites/default/files/media_asset/HIV_Law_AfricanHumanRightsSystem_en.pdf
2. African Commission on Human and Peoples' Rights. (1979). Banjul Charter. Retrieved from <http://www.achpr.org/instruments/achpr/#a16>
3. Agaya, J., Nnadi, C. D., Odhiambo, J., Obonyo, C., Obiero, V., Lipke, V., . . . Oeltmann, J. E. (2015). Tuberculosis and latent tuberculosis infection among healthcare workers in Kisumu, Kenya. *Trop Med Int Health*, 20(12), 1797-1804. doi:10.1111/tmi.12601
4. Amref. (2013). Amref Health Africa. Fighting Malaria at the Community and Household Level. Retrieved from <https://www.amrefcanada.org/media-centre/stories/fighting-malaria-at-the-community-and-household-level/>
5. Amref. (2017a). Amref receives Ksh 4.6 billion grant to fight TB and Malaria in Kenya. Retrieved from <https://amref.org/news/amref-receives-ksh-4-6-billion-grant-fight-tb-malaria-kenya/>
6. Amref. (2017b). National Treasury Kenya & Amref Health Africa. The Global Fund Funding Request Application From [full] Malaria. Retrieved from
7. Amref. (2018). Amref Health Africa. Community Workers Help Reduce Costs of Treating Malaria. Retrieved from <https://amref.org/news/community-workers-help-reduce-costs-treating-malaria/>
8. Amuyunzu-Nyamongo, M., Okeng'o, L., Wagura, A., & Mwenzwa, E. (2007). Putting on a brave face: The experiences of women living with HIV and AIDS in informal settlements of Nairobi, Kenya. *AIDS Care - Psychological and Socio-Medical Aspects of AIDS/HIV*, 19(SUPPL.1), S25-S34. doi:10.1080/09540120601114618
9. Ayele, D. G., & Shifa, M. (2017). Socio-Economic Determinants of Poverty in Malaria Endemic Areas of Kenya. *Current Journal of Applied Science and Technology*, 22. doi:DOI: 10.9734/CJAST/2017/34660
10. Baral, S. D., Poteat, T., Stromdahl, S., Wirtz, A. L., Guadamuz, T. E., & Beyrer, C. (2013). Worldwide burden of HIV in transgender women: a systematic review and meta-analysis. *Lancet Infect Dis*, 13(3), 214-222. doi:10.1016/s1473-3099(12)70315-8
11. Bhattacharjee, P., McClarty, L. M., Musyoki, H., Anthony, J., Kioko, J., Kaosa, S., . . . Moses, S. (2015). Monitoring HIV prevention program outcomes among key populations in Kenya: Findings from a national survey. *PLoS ONE*, 10(8). doi:10.1371/journal.pone.0137007

12. BHESP. (2017). BHESP rolls out PrEP pills to fight HIV [Press release]. Retrieved from <https://www.bhesp.org/index.php/2015-08-24-17-52-33/newsletter>
13. BHESP. (2019a). About Us. Retrieved from <https://www.bhesp.org/index.php/2016-02-29-10-29-39/bhesp>
14. BHESP. (2019b). Human Rights and Advocacy. Retrieved from <https://www.bhesp.org/index.php/2015-08-24-17-22-52/human-rights-advocacy>
15. Boakye, M. D. S., Owek, C. J., Oluoch, E., Wachira, J., & Afrane, Y. A. (2018). Challenges of achieving sustainable community health services for community case management of malaria. *BMC Public Health*, 18(1 %@ 1471-2458), 1150. doi:10.1186/s12889-018-6040-2 %U <https://doi.org/10.1186/s12889-018-6040-2>
16. Bond, V., Floyd, S., Fenty, J., Schaap, A., Godfrey-Faussett, P., Claassens, M., . . . Hargreaves, J. R. (2017). Secondary analysis of tuberculosis stigma data from a cluster randomised trial in Zambia and South Africa (ZAMSTAR). *Int J Tuberc Lung Dis*, 21(11), 49-59. doi:10.5588/ijtld.16.0920
17. Brentlinger, P. E. (2006). Health, Human Rights, and Malaria Control: Historical Background and Current Challenges. JSTOR - The President and Fellow of Harvard College.
18. CHAK. (2017). HIV and Human Rights: Contribution of Church health facilities in eliminating Stigma and Discrimination. Retrieved from https://www.chak.or.ke/publications.php?tag=frame_view&id=31
19. Chuma, J., Okungu, V., & Molyneux, C. (2010). Barriers to prompt and effective malaria treatment among the poorest population in Kenya. *Malaria Journal*, 9. doi: 10.1186/1475-2875-9-144
20. Chuma, J., Okungu, V., Ntwiga, J., & Molyneux, C. (2010). Towards achieving Abuja targets: identifying and addressing barriers to access and use of insecticides treated nets among the poorest populations in Kenya. *BMC Public Health*. doi: 10.1186/1471-2458-10-137
21. Colombini, M., James, C., Ndwiga, C., & Mayhew, S. H. (2016). The risks of partner violence following HIV status disclosure, and health service responses: narratives of women attending reproductive health services in Kenya. *J Int AIDS Soc*, 19(1), 20766. doi:10.7448/ias.19.1.20766
22. Community Health Unit - Ministry of Health. (2014). Strategy for Community Health 2014-2019 - Transforming health: Accelerating the attainment of health goals. Retrieved from <http://guidelines.health.go.ke/#/category/12/90/meta>
23. Department of Health Services County Government of Mombasa. (2018). Mombasa County Adolescent and Young People Strategy on HIV and Sexual Reproductive Health.

Retrieved from http://www.mombasa.go.ke/wp-content/uploads/2018/11/Mombasa-AYPStrategy-8_11_2018.pdf

24. Dewing, S., Plüddemann, A., Myers, B. J., & Parry, C. D. H. (2006). Review of injection drug use in six African countries: Egypt, Kenya, Mauritius, Nigeria, South Africa and Tanzania. *Taylor & Francis Online*, 13(2).
25. Division of Malaria Control Ministry of Public Health and Sanitation. (2009). National Malaria Strategy 2009-2017. Retrieved from http://www.nationalplanningcycles.org/sites/default/files/country_docs/Kenya/kenya_national_malaria_strategy_2009-2017.pdf
26. Dworkin, S. L., Grabe, S., Lu, T., Hatcher, A. M., Kwena, Z., Bukusi, E., & Mwaura-Muiru, E. (2013). Property rights violations as a structural driver of women's HIV risks: a qualitative study in Nyanza and Western Provinces, Kenya. *Arch Sex Behav*, 42(5), 703-713. doi:10.1007/s10508-012-0024-6
27. East African Legislative Assembly. (2012). The East African Community HIV and AIDS Prevention and Management Act. Retrieved from <http://www.kelinkkenya.org/wp-content/uploads/2017/04/EAC-HIV-ACT-2012.pdf>
28. Enos, M., Sitienei, J., Ong'ang'o, J., Mungai, B., Kamene, M., Wambugu, J., . . . Weyenga, H. (2018). Kenya tuberculosis prevalence survey 2016: Challenges and opportunities of ending TB in Kenya. *PLoS One*, 13(12), e0209098. doi:10.1371/journal.pone.0209098
29. Equal Eyes. (2019). Kenya: Jeffrey Walimbwa on Improving HIV Services for Key Populations. Retrieved from <https://equal-eyes.org/database/2019/2/3/kenya-jeffrey-walimbwa-on-improving-hiv-services-for-key-populations>
30. Eric Gitari v. Non-Governmental Organizations. (2013). Petition 440 of 2013. Retrieved from <http://kenyalaw.org/caselaw/cases/view/108412/>
31. Ferguson, A. G., & Morris, C. N. (2007). Mapping transactional sex on the Northern Corridor highway in Kenya. *Health and Place*, 13(2), 504-519.
32. FIDA Kenya. (2008). Documenting Human Rights Violations of Sex Workers in Kenya. Retrieved from https://www.opensocietyfoundations.org/sites/default/files/fida_20081201.pdf
33. Fogel, J. M., Sandfort, T., Zhang, Y., Guo, X., Clarke, W., Breaud, A., . . . Eshleman, S. H. (2019). Accuracy of Self-Reported HIV Status Among African Men and Transgender Women Who Have Sex with Men Who were Screened for Participation in a Research Study: HPTN 075. *AIDS Behav*, 23(1), 289-294. doi:10.1007/s10461-018-2231-1
34. Girls Not Brides. (2018a). Child marriage and HIV: Thematic Brief. Retrieved from <https://www.girlsnotbrides.org/wp-content/uploads/2018/07/Child-marriage-and-HIV-18th-July-clean.pdf>

35. Girls Not Brides. (2018b). Kenya - What's the Child Marriage Rate? How Big of an Issue is Child Marriage? Retrieved from <https://www.girlsnotbrides.org/child-marriage/kenya/>
36. Gruskin, S., Safreed-Harmon, K., Ezer, T., Gathumbi, A., Cohen, J., & Kameri-Mbote, P. (2013). Access to justice: evaluating law, health and human rights programs in Kenya. *Journal of the International AIDS Society*, 16(3 Suppl 2).
37. Guise, A., Rhodes, T., Ndimbii, J., Ayon, S., & Nnaji, O. (2016). Access to HIV treatment and care for people who inject drugs in Kenya: a short report. *AIDS Care - Psychological and Socio-Medical Aspects of AIDS/HIV*, 28(12), 1595-1599. doi:10.1080/09540121.2016.1191606
38. Harper, G. W., Riplinger, A. J., Neubauer, L. C., Murphy, A. G., Velcoff, J., & Bangi, A. K. (2014). Ecological factors influencing HIV sexual risk and resilience among young people in rural Kenya: implications for prevention. *Health Educ Res*, 29(1), 131-146. doi:10.1093/her/cyt081
39. Harvard School of Public Health - Program on International Health and Human Rights. (2011). Evaluating the Integration of Legal Support and Health Care in Kenya: Findings from the Second Phase of the Evaluation. Retrieved from https://namati.org/wp-content/uploads/2015/12/Harvard_2011-Evaluation-of-Legal-Integration-in-Kenya_-Final-Phase-Report.pdf
40. Hill, Hoyt, van Eijk, D'Mello-Guyett, ter Kuile, Steketee, . . . Webster. (2013). Factors Affecting the Delivery , Access, and Use of Interventions to Prevent Malaria in Pregnancy in Sub-Saharan Africa: A Systematic Review and Meta-Analysis. *PLOS Medicine*, 10(7).
41. Hill, J., Hoyt, J., van Eijk, A. M., D'Mello-Guyett, L., ter Kuile, F. O., Steketee, R., . . . Webster, J. (2013). Factors Affecting the Delivery , Access, and Use of Interventions to Prevent Malaria in Pregnancy in Sub-Saharan Africa: A Systematic Review and Meta-Analysis. *PLOS Medicine*, 10(7).
42. Hill, J., Kayentao, K., Achieng, F., Diarra, S., Dellicour, S., Diawara, S. I., . . . Webster, J. (2015). Access and use of interventions to prevent and treat malaria among pregnant women in Kenya and Mali: a qualitative study. *PLoS One*, 10(3), e0119848. doi:10.1371/journal.pone.0119848
43. Human Rights Count. (2015). Speaking Out: Personal testimonies of rights violations experienced by sex workers in Kenya. Retrieved from <https://www.nswp.org/sites/nswp.org/files/Speaking%20Out%20Kenya%2C%20GNP%2B%2C%20KESWA%20-%202015.pdf>
44. Human Rights Watch. (2003). Double Standards: Women's Property Rights Violation in Kenya. Retrieved from <https://www.hrw.org/sites/default/files/reports/kenya0303.pdf>
45. Human Rights Watch. (2015). The Issue is Violence - Attack on LGBT People on Kenya's Coast. Retrieved from https://www.hrw.org/sites/default/files/report_pdf/kenya0915_4upr.pdf

46. Human Rights Watch. (2016). Dignity Debased - Forced Anal Examinations in Homosexuality Prosecutions. Retrieved from https://www.hrw.org/sites/default/files/report_pdf/globalgbtanalexams0716web.pdf
47. IDLO. (2017). Kenya's First Legal Aid Action Plan Formally Launched. Retrieved from <https://www.idlo.int/news/highlights/kenya-first-legal-aid-action-plan-formally-launched>
48. Institute for Health Metrics and Evaluation. (2018). GBD Compare Data Visualization.
49. IntraHealth. (2016). New Project in Kenya Will Bring Health Care to the Country's Most Vulnerable. Retrieved from <https://www.intrahealth.org/page/new-project-in-kenya-will-bring-health-care-to-the-countrys-most-vulnerable->
50. IOM. (2011). An Analysis of Migration Health in Kenya. Retrieved from http://kenya.iom.int/sites/default/files/2011_AN_ANALYSIS_OF_MIGRATION_HEALTH_IN_KE_NYA_-_final.pdf
51. ISHTAR. (2019). MSM Health and Social Wellbeing. Retrieved from <http://www.ishtarmsm.org/#services-wrapper>
52. Izugbara, C. O., & Wekesa, E. (2011). Beliefs and practices about antiretroviral medication: A study of poor urban Kenyans living with HIV/AIDS. *Sociology of Health and Illness*, 33(6), 869-883. doi:10.1111/j.1467-9566.2010.01328.x
53. Jakubowski, A., Omanga, E., Agot, K., & Thirumurthy, H. (2016). Large Price Premiums for Unprotected Sex Among Female Sex Workers in Kenya: A Potential Challenge for Behavioral HIV Prevention Interventions. *Journal of Acquired Immune Deficiency Syndromes*, 72(1), e20-22. <http://dx.doi.org/10.1097/QAI.0000000000000929>
54. KANCO. (2019). HIV & AIDS. Retrieved from https://kanco.org/?page_id=690
55. Kanyina, E. W., Boru, W. G., Mucheru, G. M., Amwayi, S. A., & Galgalo, T. (2017). Tuberculosis infection among health care workers: a case series in two district hospitals, Kenya, August 2013. *Pan Afr Med J*, 28(Suppl 1), 4. doi:10.11604/pamj.suppl.2017.28.1.8222
56. Kazungu, J. S., & Barasa, E. W. (2017). Examining levels, distribution and correlates of health insurance coverage in Kenya. *Trop Med Int Health*, 22(9), 1175-1185. doi:10.1111/tmi.12912
57. KELIN. (2010a). Constitution 2010 - How the Constitution Protects HIV Related Rights. Retrieved from <http://kelinkenya.org/wp-content/uploads/2010/10/How-the-Constitution-Protects-HIV-Related-Rights.pdf>
58. KELIN. (2010b). Scaling Up HIV-Related Legal Services - Report of Case Studies: Ukraine, Kenya and India. Retrieved from <http://kelinkenya.org/wp-content/uploads/2010/10/100901-HIV-Legal-Services-Case-Studies-IDLO-UNAIDS2.pdf>

59. KELIN. (2012a). Study on Human Rights Violations Against People Living with HVI and AIDS in Kenya. Retrieved from
60. KELIN. (2012b). What is the East African Community HIV & AIDS Prevention and Management Bill, 2012? Retrieved from http://kelinkenya.org/wp-content/uploads/2010/10/QA_EALA_Bill_5July_Final1.pdf
61. KELIN. (2012c). Workshop on Human Rights and the Legal Protection in Relation to HIV. Retrieved from http://kelinkenya.org/wp-content/uploads/2010/10/Report-on-the-Training-of-on-legal-protection-in-relation-to-HIV_opt.pdf
62. KELIN. (2013a). Regional Capacity Building Workshop - for senior law enforcement officer on HIV, Human Rights and the Law. Retrieved from <https://hivlawcommission.org/wp-content/uploads/2017/06/Regional-Capacity-Building-Workshop-for-Senior-Law-Enforcement-Officers-on-HIV-Human-Rights-the-Law-Meeting-Report.pdf>
63. KELIN. (2013b). Report of the Sensitization Forum for Health Care Workers on HIV Law and Human Rights in Mombasa and Kilifi County. Retrieved from <http://kelinkenya.org/wp-content/uploads/2010/10/Health-Care-Workers-Sensitization-Workshop-Report.pdf>
64. KELIN. (2014a). Capacity Building Workshop Report on Human Rights and the Law in Relation to HIV and TB in Prison. Retrieved from <http://kelinkenya.org/wp-content/uploads/2010/10/Capacity-Building-Workshop-REport-on-Human-Rights-and-the-Law-in-Relation-to-HIV-TB-in-Prison.pdf>
65. KELIN. (2014b). HIV, Human Rights and the Law for Health Care Workers in Nakuru and Uasin Gishu Counties. Retrieved from <http://kelinkenya.org/wp-content/uploads/2010/10/HIV-Human-Rights-the-Law-for-Health-Care-Workers-in-Nakuru-and-Uashin-Gishu-Counties.pdf>
66. KELIN. (2014c). Punitive Laws and Practices Affecting HIV Responses in Kenya. Retrieved from <http://kelinkenya.org/wp-content/uploads/2010/10/punitive-laws-practices-affecting-HIV-responses-in-Kenya.pdf>
67. KELIN. (2014d). Report of High Level Meeting with Senior Officers on Management of HIV and TB for the Prison Population in Kenya. Retrieved from <http://kelinkenya.org/wp-content/uploads/2010/10/Report-for-Senior-Prisons-Officers-on-the-Rights-Based-Management-to-HIV-and-TB.pdf>
68. KELIN. (2014e). Research Findings - Privacy & Confidentiality for PLHIV Accessing Health Services. Retrieved from <https://hivlawcommission.org/wp-content/uploads/2017/06/Research-Findings-on-Privacy-Confidentiality-for-PLHIV-Accessing-Health-Sevices-in-Nairobi-County.pdf>
69. KELIN. (2014f). Tag Archives: 605 of 2014. Retrieved from <http://kelin.kelinkenya.org/index.php/tag/petition-605-of-2014/>

70. KELIN. (2014g). Training on the Link Between HIV & Human Rights, Governance and the Legislative Process. Retrieved from <http://kelinkenya.org/wp-content/uploads/2014/06/Mombasa-Training-.pdf>
71. KELIN. (2015a). Open Letter to the Clerk, Kenya National Assembly
72. RE: Need for Public Participation in the Health Bill 2015 In.
73. KELIN. (2015b). Training on HIV, Human Rights, the Law and Documentation of Human Rights Violation in Kwale County. Retrieved from <http://kelinkenya.org/wp-content/uploads/2010/10/Report-on-HIV-HUMAN-RIGHTS-THE-LAW-AND-HARM-REDUCTION1.pdf>
74. KELIN. (2016a). Eighty three health care workers and law enforcement officers sensitized on HIV & TB rights. Retrieved from <http://www.kelinkenya.org/eighty-three-health-care-workers-law-enforcement-officers-sensitized-hiv-tb-rights/>
75. KELIN. (2016b). Monitoring the Implementation. Retrieved from <http://www.kelinkenya.org/wp-content/uploads/2016/11/FINAL-TRAINING-MANUAL-NOV-2016.pdf>
76. KELIN. (2016c). Punitive Laws Affecting Sex Workers. Retrieved from <https://www.bhesp.org/index.php/2015-08-24-17-52-33?download=5:punitive-laws-affecting-sex-workers>
77. KELIN. (2017a). KELIN set to empower community health advocates on health related rights. Retrieved from <http://www.kelinkenya.org/kelin-set-empower-community-health-advocates-health-related-rights/>
78. KELIN. (2017b). The Nairobi Strategy: A Human Rights-based Approach to Tuberculosis. Retrieved from <http://www.stoptb.org/assets/documents/communities/NairobiTBStrategyFINAL.pdf>
79. KELIN. (2018a). County Dialogue Forum on HIV, TB, Sexual Reproductive Health and Human Rights - Mombasa County. Retrieved from <http://www.kelinkenya.org/wp-content/uploads/2018/05/County-Dialogue-Mombasa-County.pdf>
80. KELIN. (2018b). County Dialogue Forum on HIV, TB, Sexual Reproductive Health and Human Rights - Nairobi County. Retrieved from <http://www.kelinkenya.org/wp-content/uploads/2018/05/County-Dialogue-Nairobi-County.pdf>
81. KELIN. (2018c). KELIN emphasises the need for informed consent and data protection safeguards in the development of NASCOP's Assisted Partner Notification Guidelines. Retrieved from <https://www.kelinkenya.org/kelin-emphasises-the-need-for-informed-consent-and-data-protection-safeguards-in-the-development-of-nascops-assisted-partner-notification-guidelines/>

82. KELIN. (2018d). People living with HIV challenge discriminatory laws that criminalize HIV exposure and transmission. Retrieved from <http://www.kelinkenya.org/people-living-with-hiv-challenge-discriminatory-laws-that-criminalize-hiv-exposure-and-transmission/>
83. KELIN. (2018e). Report of the County Dialogue Forums on HIV, TB, Sexual Reproductive Health and Human Rights - Kisumu County. In.
84. KELIN. (2018f). Sensitization on Advocates for TB and Human Rights. Retrieved from <https://amref.org/wp-content/uploads/2018/09/Expression-of-Interest-Sensitisation-of-Lawyers-on-TB-and-Human-Rights.pdf>
85. KELIN. (2018g). Trends in HIV & TB Human Rights Violations and Interventions. In.
86. KELIN. (2018h). Tuberculosis: A Gender Assessment in Kenya. In.
87. KELIN. (2018i). Tuberculosis: An Assessment of the Legal Environment, Kenya. In.
88. KELIN. (2018j). Tuberculosis: Data Assessment in Key, Vulnerable, And Underserved Populations in Kenya. In.
89. KELIN. (2019). Strategic Litigation. Retrieved from <http://www.kelinkenya.org/strategic-litigation/>
90. Kenya Gazette Supplement. (2017). The Health Act. In.
91. Kenya Human Rights Commission. (2017). The Human Rights Situation, Case Law, and Research on Protections on Grounds of Sexual Orientation, Gender Identity, and Expression in the Republic of Kenya. Retrieved from <https://static1.squarespace.com/static/581a19852994ca08211faca4/t/593945a41b10e322cb15ac71/1496925610274/KENYA+IE-SOGI+SUBMISSION.pdf>
92. Kenya Law. (2010). Petition 97 of 2010. Retrieved from <http://kenyalaw.org/caselaw/cases/view/107033/>
93. Kenya Law. (2016). Civil Appeal 56 of 2016. Retrieved from <http://kenyalaw.org/caselaw/cases/view/150781/>
94. Kenya National Bureau of Statistics. (2008). Kenya Demographic and Health Survey 2008-09. Retrieved from <https://dhsprogram.com/pubs/pdf/FR229/FR229.pdf>
95. Kenya National Bureau of Statistics. (2015a). Kenya Demographic and Health Survey 2014. Retrieved from Nairobi, Kenya: <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>
96. Kenya National Bureau of Statistics. (2015b). Kenya Integrated Household Budget Survey. In.

97. Kenya National Bureau of Statistics. (2016). Economic Survey 2016. Retrieved from <https://www.knbs.or.ke/download/economic-survey-2016/>
98. Kenya National Bureau of Statistics. (2017a). Kisumu County Data. Retrieved from <https://www.knbs.or.ke/download/kisumu-county/>
99. Kenya National Bureau of Statistics. (2017b). Mombasa County Data. Retrieved from <https://www.knbs.or.ke/download/mombasa-county/>
100. Kenya National Bureau of Statistics. (2018). Economic Survey 2018. Retrieved from <https://www.knbs.or.ke/download/economic-survey-2018/>
101. Kenya National Commission on Human Rights. (2018). Submissions to the Office of the High Commissioner for Human Rights on Implementation of the Joint Commitment to Effectively Addressing and Countering the World Drug Problem with Regards to Human Rights. Retrieved from <https://www.ohchr.org/Documents/HRBodies/HRCouncil/DrugProblem/HRC39/KenyaNationalHRC.docx>
102. Kerrigan, D., Kennedy, C. E., Morgan-Thomas, R., Reza-Paul, S., Mwangi, P., Win, K. T., . . . Butler, J. (2015). A community empowerment approach to the HIV response among sex workers: Effectiveness, challenges, and considerations for implementation and scale-up. *The Lancet*, 385(9963), 172-185. doi:10.1016/S0140-6736(14)60973-9
103. Key Populations Brief. (2016a). Healthcare Workers. In.
104. Key Populations Brief. (2016b). Living with HIV. In.
105. Key Populations Brief. (2016c). Mobile Populations. In.
106. Kisumu County Health Department. (2014). Kisumu - County AIDS Strategic Plans. Retrieved from <https://nacc.or.ke/county-aids-strategic-plans-casps/#>
107. Kizito, K. W., Dunkley, S., Kingori, M., & Reid, T. (2011). Lost to follow up from tuberculosis treatment in an urban informal settlement (Kibera), Nairobi, Kenya: what are the rates and determinants? *Trans R Soc Trop Med Hyg*, 105(1), 52-57. doi:10.1016/j.trstmh.2010.08.015
108. Kose, J., Tiam, A., Ochuka, B., Okoth, E., Sunguti, J., Waweru, M., . . . Rakhmanina, N. (2018). Impact of a Comprehensive Adolescent-Focused Case Finding Intervention on Uptake of HIV Testing and Linkage to Care Among Adolescents in Western Kenya. *J Acquir Immune Defic Syndr*, 79(3), 367-374. doi:10.1097/qai.0000000000001819
109. Liefooghe, R., Baliddawa, J. B., Kipruto, E. M., Vermeire, C., & De Munynck, A. O. (1997). From their own perspective. A Kenyan community's perception of tuberculosis. *Trop Med Int Health*, 2(8), 809-821.

110. LINKAGES. (2016). The Nexus of Gender and HIV among Transgender People in Kenya. Retrieved from <https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-kenya-tg-gender-analysis-2016.pdf>
111. LINKAGES. (2017). Linkages Across the Continuum of HIV Services for Key Population Affected by HIV - Gender Strategy. Retrieved from <https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-gender-strategy.pdf>
112. Living Positive Kenya. (2019). Women Economic Empowerment Program. Retrieved from <https://www.livingpositivekenya.org/programs>
113. Lukera, M. (2007). Documenting human rights violations against sex workers in Kenya. *HIV/AIDS policy & law review / Canadian HIV/AIDS Legal Network*, 12(2-3), 76-77.
114. Mack, N., Odhiambo, J., Wong, C. M., & Agot, K. (2014). Barriers and facilitators to pre-exposure prophylaxis (PrEP) eligibility screening and ongoing HIV testing among target populations in Bondo and Rarieda, Kenya: results of a consultation with community stakeholders. *BMC health services research*, 14, 231. doi:10.1186/1472-6963-14-231
115. Mainline. (2015). Drug Laws and Human Rights in Kenya: Disharmony in the Law and Training Recommendations to Law Enforcement. Retrieved from <https://www.hivgaps.org/wp-content/uploads/2015/10/34.-Drug-laws-and-human-rights-in-Kenya-Disharmony-in-the-law-and-training-recommendations-to-law-enforcement.pdf>
116. Malaria Control Unit - Ministry of Health. (2015). Gender and Malaria in Kenya. Retrieved from <https://www.measureevaluation.org/pima/malaria/gender-and-malaria-in-kenya>
117. Mauch, V., Woods, N., Kirubi, B., Kipruto, H., Sitienei, J., & Klinkenberg, E. (2011). Assessing access barriers to tuberculosis care with the tool to Estimate Patients' Costs: pilot results from two districts in Kenya. *BMC Public Health*, 11, 43. doi:10.1186/1471-2458-11-43
118. Mbithi, A., Gichangi, A., Kim, A. A., Katana, A., Weyenga, H., Williamson, J., . . . Group, K. S. (2014). Tuberculosis and HIV at the national level in Kenya: results from the Second Kenya AIDS Indicator Survey. *J Acquir Immune Defic Syndr*, 66 Suppl 1, S106-115. doi:10.1097/QAI.0000000000000120
119. Mbutia, G. W., Olungah, C. O., & Ondicho, T. G. (2018). Health-seeking pathway and factors leading to delays in tuberculosis diagnosis in West Pokot County, Kenya: A grounded theory study. *PLoS One*, 13(11), e0207995. doi:10.1371/journal.pone.0207995
120. McHenry, M. S., Nyandiko, W. M., Scanlon, M. L., Fischer, L. J., McAteer, C. I., Aluoch, J., . . . Vreeman, R. C. (2017). HIV Stigma: Perspectives from Kenyan Child Caregivers and Adolescents Living with HIV. *J Int Assoc Provid AIDS Care*, 16(3), 215-225. doi:10.1177/2325957416668995

121. McKinnon, L. R., Gakii, G., Juno, J. A., Izulla, P., Munyao, J., Ileri, N., . . . Kimani, J. (2014). High HIV risk in a cohort of male sex workers from Nairobi, Kenya. *Sex Transm Infect*, 90(3), 237-242. doi:10.1136/sextrans-2013-051310
122. Micheni, M., Kombo, B. K., Secor, A., Simoni, J. M., Operario, D., van der Elst, E. M., . . . Graham, S. M. (2017). Health Provider Views on Improving Antiretroviral Therapy Adherence Among Men Who Have Sex with Men in Coastal Kenya. *AIDS Patient Care and STDs*, 31(3), 113-121. doi:http://dx.doi.org/10.1089/apc.2016.0213
123. Micheni, M., Rogers, S., Wahome, E., Darwinkel, M., Van Der Elst, E., Gichuru, E., . . . Smith, A. D. (2015). Risk of sexual, physical and verbal assaults on men who have sex with men and female sex workers in coastal Kenya. *AIDS*, 29, S231-S236. doi:10.1097/QAD.0000000000000912
124. Ministry of Health. (2013). The Kenya National Patients' Rights Charter. Retrieved from
125. Ministry of Health. (2014a). Guidelines for TB Infection Prevention and Control for Health Care Workers in Kenya. Retrieved from <http://apps.who.int/medicinedocs/documents/s21977en/s21977en.pdf>
126. Ministry of Health. (2014b). Kenya AIDS Strategic Framework. Retrieved from <http://www.undp.org/content/dam/kenya/docs/Democratic%20Governance/KENYA%20AIDS%20STRATEGIC%20FRAMEWORK.pdf>
127. Ministry of Health. (2014c). Kenya Health Policy 2014-2030. Retrieved from http://publications.universalhealth2030.org/uploads/kenya_health_policy_2014_to_2030.pdf
128. Ministry of Health. (2014d). Kenya HIV Prevention Revolution Road Map. Retrieved from https://reliefweb.int/sites/reliefweb.int/files/resources/Kenya_HIV_Prevention_Revolution_Road_Map.pdf
129. Ministry of Health. (2014e). Kenya National Strategic Plan on Tuberculosis, Leprosy and Lung Diseases, 2015 – 2018. In.
130. Ministry of Health. (2014f). Transforming Health: Accelerating Attainment of Universal Health Coverage. Retrieved from <http://www.health.go.ke/wp-content/uploads/2016/03/KHSSP-BOOK.pdf>
131. Ministry of Health. (2016). Kenya Tuberculosis Prevalence Survey. Retrieved from http://www.kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/NarcoticDrugsandPsychotropicSubstances_Control_Act__Cap245.pdf
132. Ministry of Health. (2017a). NATIONAL GUIDELINES ON MANAGEMENT OF TUBERCULOSIS IN CHILDREN. Retrieved from <https://www.chskenya.org/wp-content/uploads/2018/03/National-Guidelines-on-Management-of-Tuberculosis-in-Children.pdf>

133. Ministry of Health. (2017b). National Tuberculosis, Leprosy and Lung Disease Program 2017. Retrieved from <https://www.nltf.co.ke/annual-reports/>
134. Ministry of Health. (2017c). The First Kenya Tuberculosis Patient Cost Survey. In.
135. Ministry of Health. (2018). National Tuberculosis, Leprosy and Lung Disease Program - Tuberculosis (TB) Isolation Policy. Retrieved from <http://www.tbonline.info/media/uploads/documents/kenya-tb-isolation-policy-2018-1.pdf>
136. Ministry of Health. (2019). Republic of Kenya - National Strategic Plan for Tuberculosis, Leprosy and Lung Health 2019-2023. Retrieved from http://www.kelinkkenya.org/wp-content/uploads/2019/03/NTLDP_Strategy2019-2023_Final_21st-March.pdf
137. Mombasa County Health Department. (2016). Mombasa - County AIDS Strategic Plans. Retrieved from <https://nacc.or.ke/county-aids-strategic-plans-casps/#>
138. Nairobi City County Government. (2015). Nairobi - County AIDS Strategic Plans. In.
139. Naomi Van Stapele, & Lorraine Nencel. (2016). Policy Brief - Decriminalisation of sex work in Kenya. Retrieved from https://includeplatform.net/wp-content/uploads/2016/05/VU_outline_reviewed_press.pdf
140. Nasreen, S., Shokoohi, M., & Malvankar-Mehta, M. S. (2016). Prevalence of Latent Tuberculosis among Health Care Workers in High Burden Countries: A Systematic Review and Meta-Analysis. *PLoS One*, 11(10), e0164034. doi:10.1371/journal.pone.0164034
141. National AIDS and STI Control Program. (2014). 2010-2011 Integrated Biological and Behavioral Surveillance Survey among Key Populations in Nairobi and Kisumu, Kenya. Retrieved from https://globalhealthsciences.ucsf.edu/sites/globalhealthsciences.ucsf.edu/files/pub/final_report_keypops_ibbs_nov_24_2014_print.pdf
142. National AIDS and STI Control Program. (2015). The Kenya HIV Testing Services Guidelines. Retrieved from <http://www.nascop.or.ke/wp-content/uploads/2016/08/THE-KENYA-HIV-TESTING-SERVICES-GUIDELINES.pdf>
143. National AIDS Control Council. (2014). The National HIV and AIDS Stigma and Discrimination Index. Retrieved from <http://www.ke.undp.org/content/dam/kenya/docs/Democratic%20Governance/HIV%20stigma%20index.pdf>
144. National AIDS Control Council. (2015). Nairobi - County AIDS Strategic Plans. In.
145. National AIDS Control Council. (2018). Kenya HIV Estimates. Retrieved from <https://nacc.or.ke/wp-content/uploads/2018/11/HIV-estimates-report-Kenya-20182.pdf>

146. National Council for Law Reporting. (2010). Laws of Kenya - The Constitution of Kenya, 2010. Retrieved from http://www.icla.up.ac.za/images/constitutions/kenya_constitution.pdf
147. National Council for Law Reporting. (2012a). Laws of Kenya - Malaria Prevention Act, Chapter 246. Retrieved from <http://guidelines.health.go.ke:8000/media/MalariaPreventionAct19of1929.pdf>
148. National Council for Law Reporting. (2012b). Laws of Kenya - Public Health Act, Chapter 242. Retrieved from <http://www.kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/PublicHealthActCap242.pdf>
149. National Malaria Control Program. (2015). Kenya Malaria Indicator Survey 2015. Retrieved from <https://dhsprogram.com/pubs/pdf/MIS22/MIS22.pdf>
150. National Malaria Control Program. (2019). Kenya Malaria Strategy 2019–2023. Retrieved from <http://www.nmcp.or.ke/index.php/resource-centre/download-centre/category/4-program-management?download=109:kms-2019-2023-signed-document>
151. National Malaria Control Program - Ministry of Health. (2016). Kenya Malaria Communication Strategy 2016-2021. Retrieved from https://www.thecompassforsbc.org/sites/default/files/strengthening_tools/Kenya%20SBCC%202016-2020.pdf
152. NGLHRC. (2019). Mission and Values.
153. NHIF. (2019a). Linda Mama Services. Retrieved from <http://www.nhif.or.ke/healthinsurance/lindamamaServices>
154. NHIF. (2019b). Out Patient facilities for NHIF Supa Cover. Retrieved from http://www.nhif.or.ke/healthinsurance/uploads/medicalFacility/Out_Patient_Facilities_For_NHIF_Supa_Cover.pdf
155. NHIF. (2019c). Outpatient Services. Retrieved from <http://www.nhif.or.ke/healthinsurance/outpatientServices>
156. Njoroge, F. K., Kimani, V. N., Ongore, D., & Akwale, W. S. (2009). Use of insecticide treated bed nets among pregnant women in Kilifi District, Kenya. *East Afr Med J*, 86(7), 314-322.
157. Non-governmental Organizations co-ordination Board v. EG. (2015). Civil Appeal 145 of 2015. Retrieved from <http://kenyalaw.org/caselaw/cases/view/170057/>
158. NSWP. (2017). Policy Brief - The Impact of Criminalisation Sex Workers' Vulnerability to HIV and Violence. Retrieved from https://www.nswp.org/sites/nswp.org/files/impact_of_criminalisation_pb_prf01.pdf

159. Nyblade, L., Reddy, A., Mbote, D., Kraemer, J., Stockton, M., Kemunto, C., . . . Barker, C. (2017). The relationship between health worker stigma and uptake of HIV counseling and testing and utilization of non-HIV health services: the experience of male and female sex workers in Kenya. *AIDS Care*, 29(11), 1364-1372. doi:10.1080/09540121.2017.1307922
160. Odeny, B. M., Pfeiffer, J., Farquhar, C., Igonya, E. K., Gatuguta, A., Kagwaini, F., . . . Bosire, R. (2016). The Stigma of Exclusive Breastfeeding Among Both HIV-Positive and HIV-Negative Women in Nairobi, Kenya. *Breastfeed Med*, 11(5), 252-258. doi:10.1089/bfm.2016.0014
161. Oduor, M. (2018). A Critical Overview of the Health Act 2017.
162. Office of the Attorney General and Department of Justice. (2017). National Action Plan: Legal Aid 2017-2022 Kenya - Towards Access to Justice for All. Retrieved from <https://www.statelaw.go.ke/wp-content/uploads/2017/12/NAP-Legal-Aid-2017-2022.pdf>
163. OHCHR & WHO. (2008). The Right to Health. Fact Sheet No. 31. Retrieved from <https://www.ohchr.org/Documents/Publications/Factsheet31.pdf>
164. Okal, J., Chersich, M. F., Tsui, S., Sutherland, E., Temmerman, M., & Luchters, S. (2011). Sexual and physical violence against female sex workers in Kenya: A qualitative enquiry. *AIDS Care - Psychological and Socio-Medical Aspects of AIDS/HIV*, 23(5), 612-618. doi:10.1080/09540121.2010.525605
165. Okall, D. O., Ondenge, K., Nyambura, M., Otieno, F. O., Hardnett, F., Turner, K., . . . Gust, D. A. (2014). Men who have sex with men in Kisumu, Kenya: comfort in accessing health services and willingness to participate in HIV prevention studies. *J Homosex*, 61(12), 1712-1726. doi:10.1080/00918369.2014.951261
166. Okubatsion Woldu, D. & Teka Haile, Z. (2015). Gender Roles and Perceptions of Malaria Risk in Agricultural Communities of Mwea Division in Central Kenya. *Women & Health - Taylor and Francis Group*. doi:10.1080/03630242.2014.979968
167. Open Society Institute. (2010). Mandatory Premarital HIV Testing. Retrieved from <https://www.opensocietyfoundations.org/sites/default/files/mandatory-premarital-hiv-testing-20100513.pdf>
168. Owek, C. J., Oluoch, E., Wachira, J., Estambale, B., & Afrane, Y. A. (2017). Community perceptions and attitudes on malaria case management and the role of community health workers. *Malaria Journal*, 16(1 %@ 1475-2875), 272. doi:10.1186/s12936-017-1916-7 %U <https://doi.org/10.1186/s12936-017-1916-7>
169. Oxford Human Rights Hub. (2015). Kenyan High Court Declares Law Criminalizing HIV Transmission Unconstitutional. Retrieved from <http://ohrh.law.ox.ac.uk/kenyan-high-court-declares-law-criminalizing-hiv-transmission-unconstitutional/>

170. Penal Reform International. (2015). Global Prison Trends 2015. Retrieved from <https://www.penalreform.org/resource/global-prison-trends-2015/>
171. PEPFAR. (2017). Kenya Country Operational Plan (COP) 2017 - Strategic Direction Summary. Retrieved from <https://www.pepfar.gov/documents/organization/272016.pdf>
172. PMI. (2014). President's Malaria Initiative. Protection of Refugees Through PMI-Kenya Donated Insecticides. Retrieved from <https://www.pmi.gov/news/stories-from-the-field/stories-from-the-field---detail/protection-of-refugees-through-pmi-kenya-donated-insecticide>
173. PMI. (2018). President Malaria Initiative, Kenya. Malaria Operational Plan FY2018. Retrieved from <https://www.pmi.gov/docs/default-source/default-document-library/malaria-operational-plans/fy-2018/fy-2018-kenya-malaria-operational-plan.pdf?sfvrsn=5>
174. PMI. (2019). President Malaria Initiative. Kenya - Malaria Operational Plan FY2019. Retrieved from <https://www.pmi.gov/docs/default-source/default-document-library/malaria-operational-plans/fy19/fy-2019-kenya-malaria-operational-plan.pdf?sfvrsn=3>
175. PMI - Kenya. (2016). Budget Breakdown by Activity (Year 9) FY2016 President's Malaria Initiative -- Kenya. Planned Malaria Obligations for FY2016. . In.
176. PMI - Kenya. (2017). Budget Breakdown by Activity President's Malaria Initiative -- Kenya Planned Malaria Obligations for FY2017. In.
177. PMI - Kenya. (2019). Budget Breakdown by Mechanism President's Malaria Initiative - KENYA Planned Malaria Obligations for FY 2019. In.
178. PSI-Kenya. (2019). Population Services International, Kenya. Malaria - About Malaria Program. Retrieved from <https://www.pskkenya.org/malaria/>
179. Reniers, G. & Watkins, S. (2010). Polygyny and the spread of HIV in sub-Saharan Africa: a case of benign concurrency. *Aids*, 24(2), 299-307. doi:10.1097/QAD.0b013e328333af03
180. Restar, A. J., Tocco, J. U., Mantell, J. E., Lafort, Y., Gichangi, P., Masvawure, T. B., . . . Sandfort, T. G. M. (2017). Perspectives on HIV pre-and postexposure prophylaxes (prep and pep) among female and male sex workers in Mombasa, Kenya: Implications for integrating biomedical prevention into sexual health services. *AIDS Education and Prevention*, 29(2), 141-153. doi:10.1521/aeap.2017.29.2.141
181. Rood, E. J. J., Mergenthaler, C., Bakker, M. I., Redwood, L., & Mitchell, E. M. H. (2017). Using 15 DHS surveys to study epidemiological correlates of TB courtesy stigma and health-seeking behavior. *Int J Tuberc Lung Dis*, 21(11), 60-68. doi:10.5588/ijtld.16.0909
182. Shangani, S., Naanyu, V., Mwangi, A., Vermandere, H., Mereish, E., Obala, A., . . . Operario, D. (2017). Factors associated with HIV testing among men who have sex with men in

- Western Kenya: a cross-sectional study. *International Journal of STD and AIDS*, 28(2), 179-187. doi:10.1177/0956462416638967
183. Siekmans, K., Sohani, S., Kisii, J., Kiilu, K., Wamalwa, E., Nelima, F., . . . Ngindu, A. (2013). Community case management of malaria: a pro-poor intervention in rural Kenya. *International Health*, 5(3).
184. Sieverding, M., Onyango, C., & Suchman, L. (2018). Private healthcare provider experiences with social health insurance schemes: Findings from a qualitative study in Ghana and Kenya. *PLoS One*, 13(2), e0192973. doi:10.1371/journal.pone.0192973
185. SRHR Africa Regional Trust (SAT). (2018). Age of Consent: Legal Review – Kenya Country Report. Retrieved from <https://www.satregional.org/wp-content/uploads/2018/05/Age-of-consent-Kenya.pdf>
186. Statistics., K. N. B. o. (2015). Kenya Demographic and Health Survey 2014. Retrieved from Nairobi, Kenya: <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>
187. Stop TB Partnership. (2011). Finding and treating people with TB in Kenya. Retrieved from http://www.stoptb.org/assets/documents/global/awards/tbreach/TBREACH_Flyer%20Lille%20KAPTLD%20Kenya.pdf
188. Stop TB Partnership. (2015a). HIV/TB Gender Assessment Workshop - Building capacity for TB activist to advance gender equality through Global Fund and national Programmes REPORT. Retrieved from <http://www.stoptb.org/assets/documents/countries/partnerships/TB%20and%20Gender%20Workshop,Nairobi%20January%20%202015.pdf>
189. Stop TB Partnership. (2015b). Tunza and Huduma Poa Clinics Improving TB Case Finding in Nyanza, Kenya. Retrieved from [http://www.stoptb.org/assets/documents/global/awards/tbreach/w4docs/Population%20Services%20International%20\(PSI\),%20Kenya.pdf](http://www.stoptb.org/assets/documents/global/awards/tbreach/w4docs/Population%20Services%20International%20(PSI),%20Kenya.pdf)
190. Stop TB Partnership. (2019). Kenya Grantee Profile - Challenge Facility for Civil Society Round 8. In.
191. Taegtmeyer, M., Muhaari, A., Davies, A., Mwangome, M., Van Der Elst, E. M., Graham, S. M., & Sanders, E. J. (2009). Challenges in addressing counselling needs of MSM in highly stigmatized contexts: Results of a qualitative study from Kenya. *HIV Medicine*, 10, 11-12. doi:10.1111/j.1468-1293.2009.00706.x
192. The Executive Office of The President. (2018). The Big Four Action Plan. Retrieved from <https://big4.president.go.ke>

193. The Global Fund. (2013). Key Population Action Plan 2014-2017. Retrieved from https://www.theglobalfund.org/media/1270/publication_keypopulations_actionplan_en.pdf
194. The Global Fund. (2014). Kenya - Grant Performance Report - KEN-S11-G11-T. Retrieved from <https://www.theglobalfund.org/en/portfolio/country/grant/?k=b449ee66-1e7c-40a4-8ded-781fc58d26a7&grant=KEN-T-AMREF>
195. The Global Fund. (2016a). The Global Fund Strategy 2017-2022: Investing to End Epidemics. Retrieved from https://www.theglobalfund.org/media/1176/bm35_02-theglobalfundstrategy2017-2022investingtoendepidemics_report_en.pdf
196. The Global Fund. (2016b). The Global Fund Sustainability, Transition and Co-financing Policy. Retrieved from https://www.theglobalfund.org/media/4221/bm35_04-sustainabilitytransitionandcofinancing_policy_en.pdf
197. The Global Fund. (2017a). Kenya - Grant Performance Report - KEN-T-AMREF. Retrieved from <https://www.theglobalfund.org/en/portfolio/country/grant/?k=b449ee66-1e7c-40a4-8ded-781fc58d26a7&grant=KEN-T-AMREF>
198. The Global Fund. (2017b). Technical Brief - HIV, Human Rights and Gender Equality. Retrieved from https://www.theglobalfund.org/media/6348/core_hivhumanrightsgenderequality_technicalbrief_en.pdf
199. The Global Fund. (2017c). Technical Brief - Malaria, Gender and Human Rights. Retrieved from https://www.theglobalfund.org/media/5536/core_malariagenderhumanrights_technicalbrief_en.pdf
200. The Global Fund. (2017d). Technical Brief - Tuberculosis, Gender and Human Rights. Retrieved from https://www.theglobalfund.org/media/6349/core_tbhumanrightsgenderequality_technicalbrief_en.pdf
201. The Global Fund. (2018). Audit Report - Global Funds to the Republic of Kenya. Retrieved from
202. The Global Fund. (2019a). Kenya - HIV/AIDS Results Profile. In.
203. The Global Fund. (2019b). Kenya - Malaria Results Profile. In.
204. The Global Fund. (2019c). Kenya - Tuberculosis Results Profile. In.
205. The Health Act No.21 of 2017. (2017). The Health Act No.21 of 2017,. In.
206. The Kenya Human Rights Commission. (2011). The Outlawed Amongst Us: A Study of the LGBTI Community's Search for Equality and non-Discrimination in Kenya. Retrieved from

207. The New Humanitarian. (2007). Slow response to high HIV rates in Prison. Retrieved from <http://www.thenewhumanitarian.org/news/2007/08/31/slow-response-high-hiv-rates-prisons>
208. The World Bank. (2015). ICR Review - Total War Against HIV/AIDS (towa) Project. Retrieved from <http://documents.worldbank.org/curated/en/237521468186529547/pdf/ICRR14771-P081712-Box393191B-PUBLIC.pdf>
209. The World Bank. (2016). Kenya Economic Update - Kazi ni Kazi: Informal should not be normal. Retrieved from <http://documents.worldbank.org/curated/en/888091467988907587/pdf/104289-NWP-PUBLIC-Kenya-Economic-Update-Copy.pdf>
210. Timberlake, S. (2017). "Human rights and gender-related barriers to HIV, TB and malaria services for purposes of the baseline assessments." (Unpublished draft). . Geneva: The Global Fund.
211. Turan, J. M., Miller, S., Bukusi, E. A., Sande, J., & Cohen, C. R. (2008). HIV/AIDS and maternity care in Kenya: how fears of stigma and discrimination affect uptake and provision of labor and delivery services. Taylor & Francis Online, 20(8).
212. UN. (1965). International Convention on the Elimination of All Forms of Racial Discrimination. Retrieved from <https://www.ohchr.org/Documents/ProfessionalInterest/cerd.pdf>
213. UN. (1966). International Covenant on Civil and Political Rights. Retrieved from
214. UN. (1984a). Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Retrieved from <https://www.ohchr.org/Documents/ProfessionalInterest/cat.pdf>
215. UN. (1984b). Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights. Retrieved from <https://www.uio.no/studier/emner/jus/humanrights/HUMR5503/h09/undervisningsmateriale/SiracusaPrinciples.pdf>
216. UN. (2007). Convention on the Rights of Persons with Disabilities and Optional Protocol.
217. UNAIDS. (2006). Organizations Working in Kenya to Address HIV and AIDS in Women. Retrieved from http://data.unaids.org/pub/report/2006/20060630_gcwa_re_directory_women_aids_kenya_en.pdf
218. UNAIDS. (2011). Women living with HIV championing the response to AIDS in Kenya. Retrieved from <http://www.unaids.org/en/resources/presscentre/featurestories/2011/october/20111031kenyawomenhiv>

219. UNAIDS. (2012). Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses. Retrieved from http://www.unaids.org/sites/default/files/media_asset/Key_Human_Rights_Programmes_en_May2012_0.pdf
220. UNAIDS. (2016). Kenya reaffirms commitment to address stigma and discrimination. Retrieved from http://www.unaids.org/en/resources/presscentre/featurestories/2016/august/20160802_Kenya_stigma
221. UNAIDS. (2017). Kenya - Country Factsheets. Retrieved from <http://www.unaids.org/en/regionscountries/countries/kenya>
222. UNAIDS. (2018a). Advocating for zero discrimination in health-care settings in Kenya [Press release]. Retrieved from <http://www.unaids.org/en/resources/presscentre/featurestories/2018/may/zero-discrimination-health-care-settings-kenya>
223. UNAIDS. (2018b). Data 2018. Retrieved from http://www.unaids.org/sites/default/files/media_asset/unaid-data-2018_en.pdf
224. UNDP and Stop TB Partnership. (2017). Legal Environment Assessments for Tuberculosis: An Operational Guide. Retrieved from http://www.stoptb.org/assets/documents/communities/StopTB_TB%20LEA%20DRAFT_FINAL_Sept%202017.pdf
225. UNESCO. (2013). Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people in Eastern and Southern Africa. Retrieved from <https://hivhealthclearinghouse.unesco.org/library/documents/ministerial-commitment-comprehensive-sexuality-education-and-sexual-and>
226. UNHCR. (2019). Kenya - Registered refugees and asylum seekers. In.
227. UNICEF. (2016). Health - UNICEF's response Malaria. Retrieved from https://www.unicef.org/health/index_malaria.html
228. USAID. (2018). Malaria in Pregnancy Country Profile - Kenya. Retrieved from https://www.mcsprogram.org/wp-content/uploads/dlm_uploads/2018/09/Kenya-MIPCountryProfile.pdf
229. Van Der Elst, E. M., Kombo, B., Gichuru, E., Omar, A., Musyoki, H., Graham, S. M., . . . Operario, D. (2015). The green shoots of a novel training programme: Progress and identified key actions to providing services to MSM at Kenyan health facilities. *Journal of the International AIDS Society*, 18(1). doi:10.7448/IAS.18.1.20226

230. van der Elst, E. M., Smith, A. D., Gichuru, E., Wahome, E., Musyoki, H., Muraguri, N., . . . Sanders, E. J. (2013). Men who have sex with men sensitivity training reduces homophobia and increases knowledge among Kenyan healthcare providers in coastal Kenya. *Journal of the International AIDS Society*, 16, 18748. doi:10.7448/IAS.16.4.18748
231. Walcott, M. M., Hatcher, A. M., Kwena, Z., & Turan, J. M. (2013). Facilitating HIV status disclosure for pregnant women and partners in rural Kenya: a qualitative study. *BMC Public Health*, 13, 1115. doi:10.1186/1471-2458-13-1115
232. Wanjiku Musili, L., & N. Mbatia, P. (2016). The Status of HIV/AIDS Management Strategies in Correctional Settings in Kenya: A Case Study of Lang'ata Women and Kamiti Maximum Prisons. *Sociology and Anthropology*.
233. Waters, K. P., Zuber, A., Willy, R. M., Kiriinya, R. N., Waudu, A. N., Oluoch, T., . . . Riley, P. L. (2013). Kenya's Health Workforce Information System: A model of impact on strategic Human Resources policy, planning and management. *International Journal of Medical Informatics*, 82.
234. WHO. (2001). A Human Rights Approach to Tuberculosis. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/66701/WHO_CDS_STB_2001.9.pdf?sequence=1&isAllowed=y
235. WHO. (2006a). Advocacy, Communication and Social Mobilization to Fight TB - A 10-year Framework for Action. Retrieved from <http://www.stoptb.org/assets/documents/resources/publications/acsm/tb-advocacy.pdf>
236. WHO. (2006b). World Health Organization. A Guide to Gender and Malaria Resources. Retrieved from
237. WHO. (2009). A Brief History of Tuberculosis Control in Kenya. Retrieved from World Health Organization: https://apps.who.int/iris/bitstream/handle/10665/43934/9789241596923_eng.pdf
238. WHO. (2010). Guidance on ethics of tuberculosis prevention, care and control. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/44452/9789241500531_eng.pdf?sequence=1
239. WHO. (2015). World Health Organization. Kenya: WHO statistical profile. In.
240. WHO. (2016). World Health Organization - Roll Back Malaria. Action and Investment to Defeat Malaria 2016-2030: For a Malaria-Free World. Retrieved from https://www.mmv.org/sites/default/files/uploads/docs/publications/RBM_AIM_Report.pdf
241. WHO. (2017a). Kenya Tuberculosis Profile. In.

242. WHO. (2017b). World Health Organization. Global Malaria Programme - Area of work - Malaria in HIV/AIDS patients. Retrieved from https://www.who.int/malaria/areas/high_risk_groups/hiv_aids_patients/en/
243. WHO. (2017c). World Health Organization. Global Malaria Programme - Area of work - Malaria in pregnant women. Retrieved from http://www.who.int/malaria/areas/high_risk_groups/pregnancy/en/
244. WHO. (2017d). World Health Organization. World Malaria Report - 2017. Retrieved from Geneva, Switzerland: <https://apps.who.int/iris/bitstream/handle/10665/259492/9789241565523-eng.pdf>
245. WHO. (2018a). Global Tuberculosis Report 2018. Retrieved from https://www.who.int/tb/publications/global_report/en/
246. WHO. (2018b). World Health Organization. Global Malaria Programme - Area of Work - Malaria in children under five. Retrieved from https://www.who.int/malaria/areas/high_risk_groups/children/en/
247. WHO. (2019a). Area of Work - Tuberculosis In Prison. Retrieved from <https://www.who.int/tb/areas-of-work/population-groups/prisons-facts/en/>
248. WHO. (2019b). HIV/AIDS - Topics: People in Prison and other closed settings. Retrieved from <https://www.who.int/hiv/topics/prisons/en/>
249. WHO. (2019c). Kenya - Country Profile. Retrieved from <https://www.who.int/countries/ken/en/>
250. WHO. (2019d). World Health Organization. Global Malaria Programme - Area of work - High-risk group. Retrieved from https://www.who.int/malaria/areas/high_risk_groups/en/
251. WHO Africa. (2018). Building Health: Kenya's Move to Universal Health Coverage. Retrieved from <https://www.afro.who.int/news/building-health-kenyas-move-universal-health-coverage>
252. WOTRO Science for Global Development in The Hague. (2016). Policy Brief - Decriminalisation of sex work in Kenya. Retrieved from https://includeplatform.net/wp-content/uploads/2016/05/VU_outline_reviewed_press.pdf

Annex 14: Documents Received and Reviewed After In-Country Data Collection

1. Amakobe, H. M., & D., M. (2016). Increasing access to HIV services for younger vulnerable female workers through their trade unions: The case of the Hair and Beauty trade union in Kenya.
2. Amakobe, H. M., Muema, I. K., & Chumo, E. K. (2014). Institutionalizing HIV Workplace Programmes in the Informal Economy in Kenya.
3. Amakobe, H. M., Nzola, J., & Mwangi, P. (2016). How can we increase access to HIV services for key populations through the workplace?
4. AMREF. (2017). Kenya Funding Request Application.
5. AMREF. (2018). Rapid Assessment report on the Implementation of Integrated HIV, TB and Malaria Services at the Community Level in Rangwe, Emuhaya and Lungalunga Sub-Counties, Kenya.
6. BHESP. (2016). OSIEA Grant Application.
7. BHESP. (2017). Quarterly Narrative Report.
8. BHESP. (2018). Narrative Report.
9. BHESP. (n.d.). OSIEA Budget.
10. COFAS. (2019a). Activity report: Community forum for advanced and sustainable development.
11. COFAS. (2019b). Cabinet paper.
12. COFAS. (2019c). Concept note: Kisumu safe home for girls and women project.
13. DANIDA. (2018a). Briefing Paper: Devolution and local accountability assessment for Danida County Programme Kenya.
14. DANIDA. (2018b). DANIDA Progress Report.
15. DANIDA. (2018c). Final Report: Devolution and local accountability assessment for Danida Country Programme Kenya.
16. DANIDA. (2019a). Marsabit County Joint H6 Budget.
17. DANIDA. (2019b). Report for Quarter.
18. DPHK. (2018). DP Project Portfolios.

19. HAPA. (2019). HIV/AIDS People's Alliance of Kenya January-March, 2019 Report.
20. HAPA. (n.d.). Stigma and Discrimination Reduction Plan for Key Population Programs.
21. Turkana County Department of Health. (2018). Turkana Smart Nutrition Survey Report.
22. HealthStrat. (2015). Transforming TB and HIV Prevention, Care and Treatment (TACT) Program: Semi-Annual Progress Report for April to September 2015.
23. ILO. (2014). Integrating Social Protection and HIV Programs for Sustaining HIV Services for Informal Economy Workers.
24. ILO. (n.d.-a). Caring for care givers: Enhancing health workers' occupational safety and health relating to HIV and TB.
25. ILO. (n.d.-b). Public-private partnerships at best: A holistic approach to prevention and economic empowerment.
26. Jinsiangu. (2018). Key Population Mapping and Size Estimation Key Findings.
27. Jinsiangu. (2019a). Enhanced Polling Booth Survey PowerPoint Presentation.
28. Jinsiangu. (2019b). Minutes of the technical meeting on Programming for Transgender People.
29. Jinsiangu. (n.d.-a). Mumias Outreach Report.
30. Jinsiangu. (n.d.-b). Outreach in Migori.
31. Jinsiangu. (n.d.-c). Report on Intersex Exchange Program in SIPD Uganda.
32. Jinsiangu. (n.d.-d). Welcome to the "TRANSIT" (Transgender Implementation Tool) PowerPoint Presentation.
33. KeNAAM. (2007). Report on Malaria Advocacy Media Training Workshop.
34. KeNAAM. (2016). Audited Financial Statements.
35. KeNAAM. (2017). Report and Financial Statements.
36. KeNAAM. (2018a). CSO Training on Malaria Social Accountability Tools Report.
37. KeNAAM. (2018b). Final Report. CRG TA Program. Malaria. Kenya. Support for Civil society engagement in the MPR process.
38. KeNAAM. (2018c). KeNAAM EAC Narrative Malaria Report.

39. KeNAAM. (2019). NGO Malaria Secretariats: Foundations for Advocacy and Impact, A Kenya Case Study.
40. MAAYGO. (2018). Annual Programmatic and Financial Report.
41. Kenya Coordinating Mechanism. (n.d.). Application Request for Matching Funds.
42. MRG. (n.d.). Draft Budget for Paralegal Training.
43. NASCOP. (2018). Minutes of the National KP Advocacy Subcommittee.
44. NEPHAK. (2018a). 2018 Annual Report.
45. NEPHAK. (2018b). Report: HIV Prevention, Treatment and Care.
46. NYARWEK. (2016). Strategic Plan NYARWEK 2016 - 2021.
47. NYARWEK. (2018a). Annual Report.
48. NYARWEK. (2018b). Hearts set on pilgrimage: Preparing LGBTI People of Faith to Participate in dialogue with religious leaders.
49. PEMA. (2018a). Faith Engagement Annual Narrative Report.
50. PEMA. (2018b). Strategic Plan 2018 - 2022.
51. PEMA. (2019). DOS Quarterly Report.
52. Reachout Centre Trust. (2018a). Afya Pwani Annual Report.
53. Reachout Centre Trust. (2018b). Reachout Centre Trust July-Dec, 2018 Report.
54. SCOPE. (2018). Health Communication & Marketing (HCM) project 2018 Reach.
55. HealthStrat. (2014a). Report on Baseline 360 ° Health Systems Assessment for Rift Valley Region Tact Supported Sites Conducted on 18th Aug to 2nd Sep 2014.
56. HealthStrat. (2014b). Report on Baseline 360 ° Health Systems Assessment for Western Region Tact Supported Sites Conducted on 26th to 28th August 2014.
57. HealthStrat. (2014c). Report on Baseline 360 ° Health Systems Assessment for Coast Region Conducted on 18th to 29th August 2014.
58. HealthStrat.. (2014d). Report on Baseline 360 ° Health Systems Assessment for Central Region Tact Supported Sites Conducted on 17th to 21st August 2014.
59. HealthStrat. (2014e). Report on Baseline 360 ° Health Systems Assessment for Eastern Region Tact Support Sites Conducted on 18th to 29th August 2014.

60. HealthStrat. (2014f). Report on Baseline 360 ° Health Systems Assessment for NAirobi Region Tact Supported Sites Conducted on 18th to 29th August 2014.
61. HealthStrat. (2014g). Report on Baseline 360 ° Health Systems Assessment for North-Eastern Region Tact Supported Sites Conducted in August 2014.
62. HealthStrat. (2014h). Report on Baseline 360 ° Health Systems Assessment for Nyanza Region Tact Supported Sites Conducted on 18th to 25th August 2014.
63. HealthStrat. (2015a). Project Narrative for the Interim Progress Report and Continuing Application.
64. HealthStrat. (2015b). Project Narrative for the Interim Progress Report and Continuing Application.
65. HealthStrat. (2016). Project Narrative for the Interim Progress Report and Continuing Application.
66. HealthStrat. (2017). Interim Project Narrative Report and Continuing Application.
67. HIV and AIDS Tribunal. (2019). Brief: Global Fund (GF) Supported Activities.
68. Trust, R. C. (2018). Advocacy OSIEA Report.
69. UNFPA. (2018). Improving Maternal and Newborn Outcomes in six high burden Maternal Mortality Counties in Kenya January 2017 - June 2020.
70. USAID. (2019). Linkages Output Data.
71. WFP. (2016). Bridging Relief and Resilience in the Arid and Semi-Arid Lands Standard Project Report 2016.
72. WFP. (2017). Bridging Relief and Resilience in the Arid and Semi-Arid Lands Standard Project Report 2017.
73. WFP. (2018a). Bridging Relief and Resilience in the Arid and Semi-Arid Lands Standard Project Report 2018.
74. WFP. (2018b). Kenya Annual Country Report 2018.
75. WOFAK. (n.d.-a). Global Fund HIV Grant Application.
76. WOFAK. (n.d.-b). Global Fund TB Grant Application.
77. WOFAK. (n.d.-c). MWENDO OVC Project in Nyanza, Western, and North Rift Counties (WOFAK).
78. LVCT Health Work. (2017). LVCT Health Work in Mombasa County.

Annex 15: Cited References

- ACHPR. (2013). 260 Resolution on Involuntary Sterilisation and the Protection of Human Rights in Access to HIV Services - ACHPR/Res.260(LIV) 2013. Retrieved from <https://www.achpr.org/sessions/resolutions?id=280>
- ACHPR. (2014). 'Resolution 275 on Protection against Violence and other Human Rights Violations against Persons on the basis of their real or imputed Sexual Orientation or Gender Identity'.
- African Commission on Human & Peoples' Rights. (2018). *HIV, The Law and Human Rights In The African Human Rights System: Key Challenges and Opportunities for Rights-Based Responses*. Retrieved from http://www.achpr.org/files/news/2017/12/d317/africancommission_hiv_report_full_eng.pdf
- African Commission on Human and Peoples' Rights. (1979). Banjul Charter. Retrieved from <http://www.achpr.org/instruments/achpr/#a16>
- Agaya, J., Nnadi, C. D., Odhiambo, J., Obonyo, C., Obiero, V., Lipke, V., . . . Oeltmann, J. E. (2015). Tuberculosis and latent tuberculosis infection among healthcare workers in Kisumu, Kenya. *Tropical Medicine & International Health*, 20(12), 1797-1804. doi:10.1111/tmi.12601
- Amakobe, H. M., Nzola, J., & Mwangi, P. (2016). How can we increase access to HIV services for key populations through the workplace?
- Amref. (2013). Amref Health Africa. Fighting Malaria at the Community and Household Level. Retrieved from <https://www.amrefcanada.org/media-centre/stories/fighting-malaria-at-the-community-and-household-level/>
- Amref. (2017). *National Treasury Kenya & Amref Health Africa. The Global Fund Funding Request Application From [full] Malaria*.
- Amref. (2018). Amref Health Africa. Community Workers Help Reduce Costs of Treating Malaria. Retrieved from <https://amref.org/news/community-workers-help-reduce-costs-treating-malaria/>
- Anyangu, A., Kikuvi, G., & Muchiri, E. M. (2010). Modifiable factors associated with active pulmonary tuberculosis in a Kenyan prison. *East African medical journal*, 87, 43-48. doi:10.4314/eamj.v87i2.60596
- Association of Kenya Medical Laboratory Scientific Officers v Ministry of Health & Attorney General*. (2019). *Constitutional Petition 282 of 2017*. Retrieved from <http://kenyalaw.org/caselaw/cases/view/174230/>
- Aywak, A., Irimu, H., Mayo, E., Okaru, C., & Bhatt, K. (2005). The prevalence of active pulmonary tuberculosis among prisoners at Kamiti Maximum Security Prison, Kenya. Retrieved from <http://erepository.uonbi.ac.ke/handle/11295/95850>
- Bhattacharjee, P., McClarty, L. M., Musyoki, H., Anthony, J., Kioko, J., Kaosa, S., . . . Moses, S. (2015). Monitoring HIV prevention programme outcomes among key populations in Kenya: Findings from a national survey. *PLoS ONE*, 10(8). doi:10.1371/journal.pone.0137007
- BHESP. (2018). ARASA Narrative Report.
- Boakye, M. D. S., Owek, C. J., Oluoch, E., Wachira, J., & Afrane, Y. A. (2018). Challenges of achieving sustainable community health services for community case management of malaria. *BMC Public Health*, 18(1 %@ 1471-2458), 1150. doi:10.1186/s12889-018-6040-2 %U <https://doi.org/10.1186/s12889-018-6040-2>

- CIA. (2019). Africa: Kenya - The World Factbook. Retrieved from <https://www.cia.gov/library/publications/the-world-factbook/geos/ke.html>
- Division of Malaria Control Ministry of Public Health and Sanitation. (2009). *National Malaria Strategy 2009-2017*. Retrieved from http://www.nationalplanningcycles.org/sites/default/files/country_docs/Kenya/kenya_national_malaria_strategy_2009-2017.pdf
- DREAMS. (2016). DREAMS overview (FY 2016-2019).
- Dworkin, S. L., Grabe, S., Lu, T., Hatcher, A. M., Kwena, Z., Bukusi, E., & Mwaura-Muiru, E. (2013). Property rights violations as a structural driver of women's HIV risks: a qualitative study in Nyanza and Western Provinces, Kenya. *Arch Sex Behav*, 42(5), 703-713. doi:10.1007/s10508-012-0024-6
- Enos, M., Sitienei, J., Ong'ang'o, J., Mungai, B., Kamene, M., Wambugu, J., . . . Weyenga, H. (2018). Kenya tuberculosis prevalence survey 2016: Challenges and opportunities of ending TB in Kenya. *PLoS One*, 13(12), e0209098. doi:10.1371/journal.pone.0209098
- Eric Gitari v. Non-Governmental Organizations. (2013). *Petition 440 of 2013*. Retrieved from <http://kenyalaw.org/caselaw/cases/view/108412/>
- Ferguson, A. G., & Morris, C. N. (2007). Mapping transactional sex on the Northern Corridor highway in Kenya. *Health and Place*, 13(2), 504-519.
- Ferguson, L., Alva, S. (2019). *Baseline assessment to reduce human rights barriers to accessing HIV, TB and malaria services: Current status*. Paper presented at the Inception Meeting, Kenya.
- FIDA Kenya. (2008). *Documenting Human Rights Violations of Sex Workers in Kenya*. Retrieved from https://www.opensocietyfoundations.org/sites/default/files/fida_20081201.pdf
- Girls Not Brides. (2018a). *Child marriage and HIV: Thematic Brief*. Retrieved from <https://www.girlsnotbrides.org/wp-content/uploads/2018/07/Child-marriage-and-HIV-18th-July-clean.pdf>
- Girls Not Brides. (2018b). *Kenya - What's the Child Marriage Rate? How Big of an Issue is Child Marriage?* Retrieved from <https://www.girlsnotbrides.org/child-marriage/kenya/>
- Global Citizen. (2019). Kenya Is Set to Open a \$100 Million Antiretroviral Factory in a Huge Step Against HIV/AIDS Retrieved from <https://www.globalcitizen.org/en/content/kenya-set-to-open-antiretroviral-factory-HIV-AIDS/>
- Guise, A., Rhodes, T., Ndimbii, J., Ayon, S., & Nnaji, O. (2016). Access to HIV treatment and care for people who inject drugs in Kenya: a short report. *AIDS Care - Psychological and Socio-Medical Aspects of AIDS/HIV*, 28(12), 1595-1599. doi:10.1080/09540121.2016.1191606
- HAPA. (2019). HIV/AIDS People's Alliance of Kenya January-March, 2019 Report. In Harper, G. W., Riplinger, A. J., Neubauer, L. C., Murphy, A. G., Velcoff, J., & Bangi, A. K. (2014). Ecological factors influencing HIV sexual risk and resilience among young people in rural Kenya: implications for prevention. *Health Educ Res*, 29(1), 131-146. doi:10.1093/her/cyt081
- Health Policy Project. 2015. *A Facilitator's Guide for Public Health and HIV Programs: Gender & Sexual Diversity Training*. Washington, DC: Futures Group, Health Policy Project.
- HealthStrat. (2015). *Transforming TB and HIV Prevention, Care and Treatment (TACT) Program: Semi-Annual Progress Report for April to September 2015*. Retrieved from HealthStrat. (2019). CDC/PEPFAR - Transforming TB & HIV Prevention, Care & Treatment in Prisons (TACT) Project.

- Human Rights Count. (2015). *Speaking Out: Personal testimonies of rights violations experienced by sex workers in Kenya*. Retrieved from <https://www.nswp.org/sites/nswp.org/files/Speaking%20Out%20Kenya%2C%20GNP%2B%2C%20KESWA%20-%202015.pdf>
- Human Rights Watch. (2003). *Double Standards: Women's Property Rights Violation in Kenya*. Retrieved from <https://www.hrw.org/sites/default/files/reports/kenya0303.pdf>
- Human Rights Watch. (2015). *The Issue is Violence - Attack on LGBT People on Kenya's Coast*. Retrieved from https://www.hrw.org/sites/default/files/report_pdf/kenya0915_4upr.pdf
- Human Rights Watch. (2016). *Dignity Debased - Forced Anal Examinations in Homosexuality Prosecutions*. Retrieved from https://www.hrw.org/sites/default/files/report_pdf/globalgbtanalexams0716web.pdf
- IDLO. (2017). Kenya's First Legal Aid Action Plan Formally Launched. Retrieved from <https://www.idlo.int/news/highlights/kenya-first-legal-aid-action-plan-formally-launched>
- ILO. (2014). Integrating Social Protection and HIV Programs for Sustaining HIV Services for Informal Economy Workers.
- International Organization for Migration, & Great Lakes Initiative on HIV/AIDS. (2006). *Long-distance Truck Drivers' Perceptions and Behaviors Towards STI/HIV/TB and Existing Health Services in Selected Truck Stops of the Great Lakes Region: a Situational Assessment*. IOM, Nairobi.
- Irant. (2019) Data Collection and Reporting on Violence Perpetrated Against LGBTQI Persons in Botswana, Kenya, Malawi, South Africa and Uganda. Prepared for the Arcus Foundation.
- Kageha, E. (2015). *Drug Laws and Human Rights in Kenya: Disharmony in the Law and Training Recommendations to Law Enforcement*. Retrieved from <https://www.hivgaps.org/wp-content/uploads/2015/10/34.-Drug-laws-and-human-rights-in-Kenya-Disharmony-in-the-law-and-training-recommendations-to-law-enforcement.pdf>
- Kanyina, E. W., Boru, W. G., Mucheru, G. M., Amwayi, S. A., & Galgalo, T. (2017). Tuberculosis infection among health care workers: a case series in two district hospitals, Kenya, August 2013. *Pan Afr Med J*, 28(Suppl 1), 4. doi:10.11604/pamj.supp.2017.28.1.8222
- Kazungu, J. S., & Barasa, E. W. (2017). Examining levels, distribution and correlates of health insurance coverage in Kenya. *Trop Med Int Health*, 22(9), 1175-1185. doi:10.1111/tmi.12912
- KELIN. (2010). *Constitution 2010 - How the Constitution Protects HIV Related Rights*. Retrieved from <http://kelinkenya.org/wp-content/uploads/2010/10/How-the-Constitution-Protects-HIV-Related-Rights.pdf>
- KELIN. (2012a). *Study on Human Rights Violations Against People Living with HVI and AIDS in Kenya*.
- KELIN. (2012b). *What is the East African Community HIV & AIDS Prevention and Management Bill, 2012?* Retrieved from http://kelinkenya.org/wp-content/uploads/2010/10/QA_EALA_Bill_5July_Final1.pdf
- KELIN. (2013). *Regional Capacity Building Workshop - for senior law enforcement officer on HIV, Human Rights and the Law*. Retrieved from <https://hivlawcommission.org/wp-content/uploads/2017/06/Regional-Capacity-Building-Workshop-for-Senior-Law-Enforcement-Officers-on-HIV-Human-Rights-the-Law-Meeting-Report.pdf>
- KELIN. (2014a). *Capacity Building Workshop Report on Human Rights and the Law in Relation to HIV and TB in Prison*. Retrieved from <http://kelinkenya.org/wp->

[content/uploads/2010/10/Capacity-Building-Workshop-REport-on-Human-Rights-and-the-Law-in-Relation-to-HIV-TB-in-Prison.pdf](#)

- KELIN. (2014b). *Punitive Laws and Practices Affecting HIV Responses in Kenya*. Retrieved from <http://kelinkenya.org/wp-content/uploads/2010/10/punitive-laws-practices-affecting-HIV-responses-in-Kenya.pdf>
- KELIN. (2014c). *Report of High Level Meeting with Senior Officers on Management of HIV and TB for the Prison Population in Kenya*. Retrieved from <http://kelinkenya.org/wp-content/uploads/2010/10/Report-for-Senior-Prisons-Officers-on-the-Rights-Based-Management-to-HIV-and-TB.pdf>
- KELIN. (2014d). *Research Findings - Privacy & Confidentiality for PLHIV Accessing Health Services*. Retrieved from <https://hivlawcommission.org/wp-content/uploads/2017/06/Research-Findings-on-Privacy-Confidentiality-for-PLHIV-Accessing-Health-Sevices-in-Nairobi-County.pdf>
- KELIN. (2014e). Tag Archives: 605 of 2014. Retrieved from <http://kelin.kelinkenya.org/index.php/tag/petition-605-of-2014/>
- KELIN. (2015). *Training on HIV, Human Rights, the Law and Documentation of Human Rights Violation in Kwale County*. Retrieved from <http://kelinkenya.org/wp-content/uploads/2010/10/Report-on-HIV-HUMAN-RIGHTS-THE-LAW-AND-HARM-REDUCTION1.pdf>
- KELIN. (2016a). Eighty three health care workers and law enforcement officers sensitized on HIV & TB rights. Retrieved from <http://www.kelinkenya.org/eighty-three-health-care-workers-law-enforcement-officers-sensitized-hiv-tb-rights/>
- KELIN. (2016b). *Monitoring the Implementation*. Retrieved from <http://www.kelinkenya.org/wp-content/uploads/2016/11/FINAL-TRAINING-MANUAL-NOV-2016.pdf>
- KELIN. (2017). KELIN set to empower community health advocates on health related rights. Retrieved from <http://www.kelinkenya.org/kelin-set-empower-community-health-advocates-health-related-rights/>
- KELIN. (2018a). *County Dialogue Forum on HIV, TB, Sexual Reproductive Health and Human Rights - Mombasa County*. Retrieved from <http://www.kelinkenya.org/wp-content/uploads/2018/05/County-Dialogue-Mombasa-County.pdf>
- KELIN. (2018b). *County Dialogue Forum on HIV, TB, Sexual Reproductive Health and Human Rights - Nairobi County*. Retrieved from <http://www.kelinkenya.org/wp-content/uploads/2018/05/County-Dialogue-Nairobi-County.pdf>
- KELIN. (2018c). People living with HIV challenge discriminatory laws that criminalize HIV exposure and transmission. Retrieved from <http://www.kelinkenya.org/people-living-with-hiv-challenge-discriminatory-laws-that-criminalize-hiv-exposure-and-transmission/>
- KELIN. (2018d). Report of the County Dialogue Forums on HIV, TB, Sexual Reproductive Health and Human Rights - Kisumu County.
- KELIN. (2018e). *Sensitization on Advocates for TB and Human Rights*. Retrieved from <https://amref.org/wp-content/uploads/2018/09/Expression-of-Interest-Sensitisation-of-Lawyers-on-TB-and-Human-Rights.pdf>
- KELIN. (2018f). Trends in HIV & TB Human Rights Violations and Interventions.
- KELIN. (2018g). Tuberculosis: A Gender Assessment in Kenya.
- KELIN. (2018h). Tuberculosis: A Gender Assessment in Kenya.
- KELIN. (2018i). Tuberculosis: An Assessment of the Legal Environment, Kenya.
- KELIN. (2018j). Tuberculosis: Data Assessment in Key, Vulnerable, And Underserved Populations in Kenya.

- KELIN. (2019a). *DREAMS End Term Evaluation Report*. Retrieved from <http://www.kelinkenya.org/wp-content/uploads/2020/03/End-of-Dreams-Final-website.pdf>
- KELIN. (2019b). Strategic Litigation. Retrieved from <http://www.kelinkenya.org/strategic-litigation/>
- KeNAAM. (2018). KeNAAM EAC Narrative Malaria Report.
- KeNAAM. (2019). EAC Narrative Malaria Report 2018-2019.
- Kenya Gazette Supplement. (2017). The Health Act.
- Kenya Human Rights Commission. (2017). *The Human Rights Situation, Case Law, and Research on Protections on Grounds of Sexual Orientation, Gender Identity, and Expression in the Republic of Kenya*. Retrieved from <https://static1.squarespace.com/static/581a19852994ca08211faca4/t/593945a41b10e322cb15ac71/1496925610274/KENYA+IE-SOGI+SUBMISSION.pdf>
- Kenya Law. (2016). Civil Appeal 56 of 2016. Retrieved from <http://kenyalaw.org/caselaw/cases/view/150781/>
- Kenya Ministry of Health. (2015). *Kenya Health Workforce Report: The Status of Healthcare Professionals in Kenya, 2015*. Retrieved from https://taskforce.org/wp-content/uploads/2019/09/KHWF_2017Report_Fullreport_042317-MR-comments.pdf
- Kenya National Bureau of Statistics. (2015a). *Kenya Demographic and Health Survey 2014*. Retrieved from Nairobi, Kenya: <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>
- Kenya National Bureau of Statistics. (2015b). Kenya Integrated Household Budget Survey. In Kenya National Bureau of Statistics. (2016). *Economic Survey 2016*. Retrieved from <https://www.knbs.or.ke/download/economic-survey-2016/>
- Kenya National Bureau of Statistics. (2018). *Economic Survey 2018*. Retrieved from <https://www.knbs.or.ke/download/economic-survey-2018/>
- KESWA. (2018). *Underage and Legally Under Protected*. Retrieved from <https://aswaalliance.org/wp-content/uploads/2019/04/KESWA-RESEARCH.pdf>
- Key Populations Brief. (2016). Mobile Populations.
- Kiptai, T., Kimono, N., Were, N., Omondi, E., Mwamsidu, C., Mungai, M., & Ulo, B. (2019). OA-09-365-31 use of “iMonitor+ ATM Kenya” an alert system to iMonitor+ ATM Kenya” an alert system to strengthen social accountability around TB, HIV and malaria in Kenya. Paper presented at the 50th World Conference on Lung Health of the International Union Against Tuberculosis and Lung Disease (The Union), Hyderabad, India
- KNCHR and ARASA. (2017). *The Kenya National Advocacy Convening on Reducing Violence and Discrimination against Key Populations*. Retrieved from <https://www.arasa.info/media/arasa/Resources/Meeting%20reports/kenya-report-final.pdf>
- LINKAGES. (2016). *The Nexus of Gender and HIV among Transgender People in Kenya*. Retrieved from <https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-kenya-tg-gender-analysis-2016.pdf>
- Lukera, M. (2007). Documenting human rights violations against sex workers in Kenya. *HIV/AIDS policy & law review / Canadian HIV/AIDS Legal Network*, 12(2-3), 76-77.
- LVCT Health. (2017). Score Card 2016-2017. Retrieved from <https://lvcthealth.org/wp-content/uploads/2018/06/LVCT-Health-Score-Card-2016-2017.pdf>
- Mainline. (2015). *Drug Laws and Human Rights in Kenya: Disharmony in the Law and Training Recommendations to Law Enforcement*. Retrieved from <https://www.hivgaps.org/wp-content/uploads/2015/10/34.-Drug-laws-and-human-rights-in-Kenya-Disharmony-in-the-law-and-training-recommendations-to-law-enforcement.pdf>
- Malaria Control Unit - Ministry of Health. (2015). *Gender and Malaria in Kenya*. Retrieved from <https://www.measureevaluation.org/pima/malaria/gender-and-malaria-in-kenya>

- Mauch, V., Woods, N., Kirubi, B., Kipruto, H., Sitienei, J., & Klinkenberg, E. (2011). Assessing access barriers to tuberculosis care with the tool to Estimate Patients' Costs: pilot results from two districts in Kenya. *BMC Public Health*, *11*, 43. doi:10.1186/1471-2458-11-43
- Mbithi, A., Gichangi, A., Kim, A. A., Katana, A., Weyenga, H., Williamson, J., . . . Group, K. S. (2014). Tuberculosis and HIV at the national level in Kenya: results from the Second Kenya AIDS Indicator Survey. *J Acquir Immune Defic Syndr*, *66 Suppl 1*, S106-115. doi:10.1097/QAI.0000000000000120
- Mburu, G., Ayon, S., Tsai, A. C., Ndimbii, J., Wang, B., Strathdee, S., & Seeley, J. (2018). "Who has ever loved a drug addict? It's a lie. They think a 'teja' is as bad person": multiple stigmas faced by women who inject drugs in coastal Kenya. *Harm Reduct J*, *15*(1), 29. doi:10.1186/s12954-018-0235-9
- McHenry, M. S., Nyandiko, W. M., Scanlon, M. L., Fischer, L. J., McAteer, C. I., Aluoch, J., . . . Vreeman, R. C. (2017). HIV Stigma: Perspectives from Kenyan Child Caregivers and Adolescents Living with HIV. *J Int Assoc Provid AIDS Care*, *16*(3), 215-225. doi:10.1177/2325957416668995
- McKinnon, L. R., Gakii, G., Juno, J. A., Izulla, P., Munyao, J., Ileri, N., . . . Kimani, J. (2014). High HIV risk in a cohort of male sex workers from Nairobi, Kenya. *Sex Transm Infect*, *90*(3), 237-242. doi:10.1136/sextrans-2013-051310
- Medecins Sans Frontieres. (2019). Shut Out and Forgotten, Refugees in Dadaab Appeal for Dignity. Retrieved from <https://msf.lu/en/news/all-news/shut-out-and-forgotten-refugees-in-dadaab-appeal-for-dignity>
- Micheni, M., Kombo, B. K., Secor, A., Simoni, J. M., Operario, D., van der Elst, E. M., . . . Graham, S. M. (2017). Health Provider Views on Improving Antiretroviral Therapy Adherence Among Men Who Have Sex with Men in Coastal Kenya. *AIDS Patient Care and STDs*, *31*(3), 113-121. doi:<http://dx.doi.org/10.1089/apc.2016.0213>
- Micheni, M., Rogers, S., Wahome, E., Darwinkel, M., Van Der Elst, E., Gichuru, E., . . . Smith, A. D. (2015). Risk of sexual, physical and verbal assaults on men who have sex with men and female sex workers in coastal Kenya. *Aids*, *29*, S231-S236. doi:10.1097/QAD.0000000000000912
- Ministry of Health. (2013). *The Kenya National Patients' Rights Charter*.
- Ministry of Health. (2014a). *Kenya AIDS Strategic Framework*. Retrieved from <http://www.undp.org/content/dam/kenya/docs/Democratic%20Governance/KENYA%20AIDS%20STRATEGIC%20FRAMEWORK.pdf>
- Ministry of Health. (2014b). *Kenya Health Policy 2014-2030*. Retrieved from http://publications.universalhealth2030.org/uploads/kenya_health_policy_2014_to_2030.pdf
- Ministry of Health. (2014c). *Kenya National Strategic Plan on Tuberculosis, Leprosy and Lung Diseases, 2015 – 2018*.
- Ministry of Health. (2014d). *Transforming Health: Accelerating Attainment of Universal Health Coverage*. Retrieved from <http://www.health.go.ke/wp-content/uploads/2016/03/KHSSP-BOOK.pdf>
- Ministry of Health. (2016). *Kenya Tuberculosis Prevalence Survey*. Retrieved from http://www.kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/NarcoticDrugsandPsychotropicSubstances_Control_Act_Cap245.pdf
- Ministry of Health. (2017a). *The First Kenya Tuberculosis Patient Cost Survey*.
- Ministry of Health. (2017b). *National Tuberculosis, Leprosy and Lung Disease Program 2017*. Retrieved from <https://www.nltp.co.ke/annual-reports/>

- Ministry of Health. (2018). *National Tuberculosis, Leprosy and Lung Disease Program - Tuberculosis (TB) Isolation Policy*. Retrieved from <http://www.tbonline.info/media/uploads/documents/kenya-tb-isolation-policy-2018-1.pdf>
- Ministry of Health. (2019). *Republic of Kenya - National Strategic Plan for Tuberculosis, Leprosy and Lung Health 2019-2023*. Retrieved from http://www.kelinkkenya.org/wp-content/uploads/2019/03/NTLDP_Strategy2019-2023_Final_21st-March.pdf
- Ministry of Health. (2020). Kenya Master Health Facility List.
- Monroe-Wise, A., Maingi Mutiti, P., Kimani, H., Moraa, H., Bukusi, D. E., & Farquhar, C. (2019). Assisted partner notification services for patients receiving HIV care and treatment in an HIV clinic in Nairobi, Kenya: a qualitative assessment of barriers and opportunities for scale-up. *Journal of the International AIDS Society*, 22(S3), e25315. doi:10.1002/jia2.25315
- Moy, H. A. (2018). Kenya's Community-Based Paralegals: A Tradition of Grassroots Legal Activism. In V. Gauri & V. Maru (Eds.), *Community Paralegals and the Pursuit of Justice* (pp. 165-209). Cambridge: Cambridge University Press.
- Moyer, E., Igonya, E. K., Both, R., Cherutich, P., & Hardon, A. (2013). The duty to disclose in Kenyan health facilities: a qualitative investigation of HIV disclosure in everyday practice. *SAHARA-J: Journal of Social Aspects of HIV/AIDS*, 10(sup1), S60-S72. Retrieved from <https://doi.org/10.1080/02664763.2012.755339>
- Müller, A., Daskilewicz, K. and the Southern and East African Research Collective on Health (2019). 'Are we doing alright? Realities of violence, mental health, and access to healthcare related to sexual orientation and gender identity and expression in Kenya: Research report based on a community-led study in nine countries'. Amsterdam: COC Netherlands.
- NACC, N. (2016). Responsive law enforcement for HIV prevention: a manual for training trainers to sensitize police on their role in a rights-based approach to HIV prevention among key populations. In. Nairobi, Kenya: Ministry of Health.
- NACC. (2020) KASF II 2020/2021-2024/2025. Presentation by Geoffrey Obonyo during validation. May 8th, 2020.
- Naomi Van Stapele, & Lorraine Nencel. (2016). *Policy Brief - Decriminalisation of sex work in Kenya*. Retrieved from https://includeplatform.net/wp-content/uploads/2016/05/VU_outline_reviewed_press.pdf
- NASCOP. (2014). *National Guidelines for HIV/STI Programming with Key Populations*. Retrieved from <http://www.icop.or.ke/wp-content/uploads/2016/10/KP-National-Guidelines-2014-NASCOP.pdf>
- NASCOP. (2017). Manual for Training Peer Educators for Programmes with Female Sex Workers.
- NASCOP. (2018). Key population mapping and size estimates: Key findings. PowerPoint Presentation.
- National AIDS and STI Control Programme. (2014). *2010-2011 Integrated Biological and Behavioral Surveillance Survey among Key Populations in Nairobi and Kisumu, Kenya*. Retrieved from https://globalhealthsciences.ucsf.edu/sites/globalhealthsciences.ucsf.edu/files/pub/final_report_keypops_ibbs_nov_24_2014_print.pdf
- National AIDS Control Council. (2014). *The National HIV and AIDS Stigma and Discrimination Index*. Retrieved from

<http://www.ke.undp.org/content/dam/kenya/docs/Democratic%20Governance/HIV%20stigma%20index.pdf>

- National AIDS Control Council. (2016). Kenya-HIV-County-Profiles-2016. Retrieved from <http://nacc.or.ke/wp-content/uploads/2016/12/Kenya-HIV-County-Profiles-2016.pdf>
- National AIDS Control Council. (2018). *Kenya AIDS Response Progress Report 2018*.
- National Council for Law Reporting. (2010). *Laws of Kenya - The Constitution of Kenya, 2010*. Retrieved from http://www.icla.up.ac.za/images/constitutions/kenya_constitution.pdf
- National Council for Law Reporting. (2012a). *Laws of Kenya - Malaria Prevention Act, Chapter 246*. Retrieved from <http://guidelines.health.go.ke:8000/media/MalariaPreventionAct19of1929.pdf>
- National Council for Law Reporting. (2012b). *Laws of Kenya - Public Health Act, Chapter 242*. Retrieved from <http://www.kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/PublicHealthActCap242.pdf>
- National Malaria Control Programme. (2015). Kenya Malaria Indicator Survey 2015. Retrieved from <https://dhsprogram.com/pubs/pdf/MIS22/MIS22.pdf>
- National Malaria Control Programme. (2019). *Kenya Malaria Strategy 2019–2023*. Retrieved from <http://www.nmcp.or.ke/index.php/resource-centre/download-centre/category/4-programme-management?download=109:kms-2019-2023-signed-document>
- National Malaria Control Programme - Ministry of Health. (2016). *Kenya Malaria Communication Strategy 2016-2021*. Retrieved from https://www.thecompassforsbc.org/sites/default/files/strengthening_tools/Kenya%20SBC%202016-2020.pdf
- National Tuberculosis Leprosy and Lung Disease Program. (2016). Immigrant health- TB Control in Kenya.
- NCAJ. (2016). *Criminal Justice System in Kenya: An Audit*. Retrieved from http://kenyalaw.org/kenyalawblog/wp-content/uploads/2017/01/Criminal_Justice_Report.pdf
- NCAJ. (2019a). Court Users' Committee Guidelines. In: National Council on Administration of Justice
- NCAJ. (2019b). *Court Users' Committee Guidelines*. Retrieved from https://www.unodc.org/documents/easternafrika//Criminal%20Justice/CUC_GUIDLINES_2019_final.pdf
- NEPHAK, BHESP, KESWA, GNP+. (2015). *Speaking Out: Personal Testimonies of Rights Violations Experienced by Sex Workers in Kenya*.
- NEPHAK. (2018a). 2018 Annual Report.
- NEPHAK. (2018b). Report: HIV Prevention, Treatment and Care.
- NGLHRC. (2019). Mission and Values.
- NHIF. (2019a). Linda Mama Services. Retrieved from <http://www.nhif.or.ke/healthinsurance/lindamamaServices>
- NHIF. (2019b). *Out Patient facilities for NHIF Supa Cover*. Retrieved from http://www.nhif.or.ke/healthinsurance/uploads/medicalFacility/Out_Patient_Facilities_For_NHIF_Supa_Cover.pdf
- NHIF. (2019c). Outpatient Services. Retrieved from <http://www.nhif.or.ke/healthinsurance/outpatientServices>
- Non-governmental Organizations co-ordination Board v. EG. (2015). *Civil Appeal 145 of 2015*. Retrieved from <http://kenyalaw.org/caselaw/cases/view/170057/>

- NSWP. (2017). *Policy Brief - The Impact of Criminalisation Sex Workers' Vulnerability to HIV and Violence*. Retrieved from https://www.nswp.org/sites/nswp.org/files/impact_of_criminalisation_pb_prf01.pdf
- Nyblade, L., Reddy, A., Mbote, D., Kraemer, J., Stockton, M., Kemunto, C., . . . Barker, C. (2017). The relationship between health worker stigma and uptake of HIV counseling and testing and utilization of non-HIV health services: the experience of male and female sex workers in Kenya. *AIDS Care*, 29(11), 1364-1372. doi:10.1080/09540121.2017.1307922
- Office of the Attorney General and Department of Justice. (2017). *National Action Plan: Legal Aid 2017-2022 Kenya - Towards Access to Justice for All*. Retrieved from <https://www.statelaw.go.ke/wp-content/uploads/2017/12/NAP-Legal-Aid-2017-2022.pdf>
- Okal, J., Chersich, M. F., Tsui, S., Sutherland, E., Temmerman, M., & Luchters, S. (2011). Sexual and physical violence against female sex workers in Kenya: A qualitative enquiry. *AIDS Care - Psychological and Socio-Medical Aspects of AIDS/HIV*, 23(5), 612-618. doi:10.1080/09540121.2010.525605
- Okall, D. O., Ondenge, K., Nyambura, M., Otieno, F. O., Hardnett, F., Turner, K., . . . Gust, D. A. (2014). Men who have sex with men in Kisumu, Kenya: comfort in accessing health services and willingness to participate in HIV prevention studies. *J Homosex*, 61(12), 1712-1726. doi:10.1080/00918369.2014.951261
- Onyuka, J. (2017). Determination Of Treatment Outcomes And Trend For Multidrug Resistant Tuberculosis Among Refugees In Dadaab Refugee Camps In Garissa County, Kenya. *Researchjournal's Journal of Public Health*, Vol. 3, 1-15.
- Open Society Institute. (2010). *Mandatory Premarital HIV Testing*. Retrieved from <https://www.opensocietyfoundations.org/sites/default/files/mandatory-premarital-hiv-testing-20100513.pdf>
- Owek, C. J., Oluoch, E., Wachira, J., Estambale, B., & Afrane, Y. A. (2017). Community perceptions and attitudes on malaria case management and the role of community health workers. *Malaria Journal*, 16(1 % @ 1475-2875), 272. doi:10.1186/s12936-017-1916-7 %U <https://doi.org/10.1186/s12936-017-1916-7>
- Oxford Human Rights Hub. (2015). Kenyan High Court Declares Law Criminalizing HIV Transmission Unconstitutional. Retrieved from <http://ohrh.law.ox.ac.uk/kenyan-high-court-declares-law-criminalizing-hiv-transmission-unconstitutional/>
- PMI. (2014). President's Malaria Initiative. Protection of Refugees Through PMI-Kenya Donated Insecticides. Retrieved from <https://www.pmi.gov/news/stories-from-the-field/stories-from-the-field---detail/protection-of-refugees-through-pmi-kenya-donated-insecticide>
- PMI. (2019). *President Malaria Initiative. Kenya - Malaria Operational Plan FY2019*. Retrieved from <https://www.pmi.gov/docs/default-source/default-document-library/malaria-operational-plans/fy19/fy-2019-kenya-malaria-operational-plan.pdf?sfvrsn=3>
- PSI-Kenya. (2019). Population Services International, Kenya. Malaria - About Malaria Program. Retrieved from <https://www.pskkenya.org/malaria/>
- Reniers, G., & Watkins, S. (2010). Polygyny and the spread of HIV in sub-Saharan Africa: a case of benign concurrency. *Aids*, 24(2), 299-307. doi:10.1097/QAD.0b013e328333af03
- Reporting, N. C. f. L. (2010). *Laws of Kenya - The Constitution of Kenya, 2010*. Retrieved from http://www.icla.up.ac.za/images/constitutions/kenya_constitution.pdf
- Restar, A. J., Tocco, J. U., Mantell, J. E., Lafort, Y., Gichangi, P., Masvawure, T. B., . . . Sandfort, T. G. M. (2017). Perspectives on HIV pre-and postexposure prophylaxes (prep and pep) among female and male sex workers in mombasa, kenya: Implications for integrating biomedical prevention into sexual health services. *AIDS Education and Prevention*, 29(2), 141-153. doi:10.1521/aeap.2017.29.2.141

- SAT. (2018). Age of Consent: Legal Review – Kenya Country Report. In: SRHR Africa Regional Trust
- Shangani, S., Naanyu, V., Mwangi, A., Vermandere, H., Mereish, E., Obala, A., . . . Operario, D. (2017). Factors associated with HIV testing among men who have sex with men in Western Kenya: a cross-sectional study. *International Journal of STD and AIDS*, 28(2), 179-187. doi:10.1177/0956462416638967
- Siekman, K., Sohani, S., Kisii, J., Kiilu, K., Wamalwa, E., Nelima, F., . . . Ngindu, A. (2013). Community case management of malaria: a pro-poor intervention in rural Kenya. *International Health*, 5(3). Retrieved from <https://academic.oup.com/inthealth/article-abstract/5/3/196/652074?redirectedFrom=fulltext>
- Statistics., K. N. B. o. (2015). *Kenya Demographic and Health Survey 2014*. Retrieved from Nairobi, Kenya: <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>
- Stop TB Partnership. (2011). *Finding and treating people with TB in Kenya*. Retrieved from http://www.stoptb.org/assets/documents/global/awards/tbreach/TBREACH_Flyer%20Lille%20KAPTLTD%20Kenya.pdf
- Stop TB Partnership. (2015a). *HIV/TB Gender Assessment Workshop - Building capacity for TB activist to advance gender equality through Global Fund and national Programmes REPORT*. Retrieved from <http://www.stoptb.org/assets/documents/countries/partnerships/TB%20and%20Gender%20Workshop,Nairobi%20January%20%202015.pdf>
- Stop TB Partnership. (2015b). *Tunza and Huduma Poa Clinics Improving TB Case Finding in Nyanza, Kenya*. Retrieved from [http://www.stoptb.org/assets/documents/global/awards/tbreach/w4docs/Population%20Services%20International%20\(PSI\),%20Kenya.pdf](http://www.stoptb.org/assets/documents/global/awards/tbreach/w4docs/Population%20Services%20International%20(PSI),%20Kenya.pdf)
- Stop TB Partnership. (2019). Kenya Grantee Profile - Challenge Facility for Civil Society Round 8.
- Stop TB Partnership. (2019a). TB Stigma Assessment: Implementation Handbook. Retrieved from: <http://www.stoptb.org/assets/documents/communities/STP%20TB%20Stigma%20Assessment%20Implementation%20Handbook.pdf>
- The Equal Rights Trust. (2012). *In the Spirit of Harambee Addressing Discrimination and Inequality in Kenya*. Retrieved from https://www.equalrightstrust.org/ertdocumentbank/In_the_Spirit_of_Harambee.pdf
- The Executive Office of The President. (2018). The Big Four Action Plan. Retrieved from <https://big4.president.go.ke>
- The Global Fund. (2013). *Key Population Action Plan 2014-2017*. Retrieved from https://www.theglobalfund.org/media/1270/publication_keypopulations_actionplan_en.pdf
- The Global Fund. (2014). *Kenya - Grant Performance Report - KEN-S11-G11-T*. Retrieved from <https://www.theglobalfund.org/en/portfolio/country/grant/?k=b449ee66-1e7c-40a4-8ded-781fc58d26a7&grant=KEN-T-AMREF>
- The Global Fund. (2016). *The Global Fund Strategy 2017-2022: Investing to End Epidemics*. Retrieved from https://www.theglobalfund.org/media/1176/bm35_02-theglobalfundstrategy2017-2022investingtoendepidemics_report_en.pdf
- The Global Fund. (2017a). *Kenya - Grant Performance Report - KEN-T-AMREF*. Retrieved from <https://www.theglobalfund.org/en/portfolio/country/grant/?k=b449ee66-1e7c-40a4-8ded-781fc58d26a7&grant=KEN-T-AMREF>
- The Global Fund. (2017b). *Technical Brief - HIV, Human Rights and Gender Equality*. Retrieved from

- https://www.theglobalfund.org/media/6348/core_hivhumanrightsgenderequality_technical_brief_en.pdf
- The Global Fund. (2017c). *Technical Brief - Malaria, Gender and Human Rights*. Retrieved from https://www.theglobalfund.org/media/5536/core_malariagenderhumanrights_technicalbrief_en.pdf
- The Global Fund. (2017d). *Technical Brief - Tuberculosis, Gender and Human Rights*. Retrieved from https://www.theglobalfund.org/media/6349/core_tbhumanrightsgenderequality_technicalbrief_en.pdf
- The Global Fund. (2019). *Technical Brief - Malaria, Gender and Human Rights*. Retrieved from https://www.theglobalfund.org/media/5536/core_malariagenderhumanrights_technicalbrief_en.pdf
- The Guardian. (2019). Kenya steps up Aids battle as building starts on \$100m drug factory. The Health Act No.21 of 2017. (2017). The Health Act No.21 of 2017.
- The Kenya Human Rights Commission. (2011). *The Outlawed Amongst Us: A Study of the LGBTI Community's Search for Equality and non-Discrimination in Kenya*.
- The World Bank. (2016). *Kenya Economic Update - Kazi ni Kazi: Informal should not be normal*. Retrieved from <http://documents.worldbank.org/curated/en/888091467988907587/pdf/104289-NWP-PUBLIC-Kenya-Economic-Update-Copy.pdf>
- Trust, R. C. (2018a). Afya Pwani Annual Report.
- Trust, R. C. (2018b). Reachout Centre Trust July-Dec, 2018 Report.
- Turan, J. M., Miller, S., Bukusi, E. A., Sande, J., & Cohen, C. R. (2008). HIV/AIDS and maternity care in Kenya: how fears of stigma and discrimination affect uptake and provision of labor and delivery services. *Taylor & Francis Online*, 20(8). Retrieved from <https://www.tandfonline.com/doi/citedby/10.1080/09540120701767224?scroll=top&needAccess=true>
- UN. (1965). *International Convention on the Elimination of All Forms of Racial Discrimination*. Retrieved from <https://www.ohchr.org/Documents/ProfessionalInterest/cerd.pdf>
- UN. (1966). *International Covenant on Civil and Political Rights*. Retrieved from
- UN. (1984a). *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. Retrieved from <https://www.ohchr.org/Documents/ProfessionalInterest/cat.pdf>
- UN. (1984b). *Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights*. Retrieved from <https://www.uio.no/studier/emner/jus/humanrights/HUMR5503/h09/undervisningsmateriale/SiracusaPrinciples.pdf>
- UN. (2007). *Convention on the Rights of Persons with Disabilities and Optional Protocol*.
- UNAIDS. (2012a). *Guidance Note on HIV and Sex Work*. Retrieved from https://www.unaids.org/sites/default/files/sub_landing/files/JC2306_UNAIDS-guidance-note-HIV-sex-work_en.pdf
- UNAIDS. (2012b). *Key Programs to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses*. Retrieved from http://www.unaids.org/sites/default/files/media_asset/Key_Human_Rights_Progras_en_May2012_0.pdf
- UNAIDS. (2018). *Data 2018*. Retrieved from http://www.unaids.org/sites/default/files/media_asset/unaid-data-2018_en.pdf

- UNDP and StopTB Partnership. (2017). *Legal Environment Assessments for Tuberculosis: An Operational Guide*. Retrieved from http://www.stoptb.org/assets/documents/communities/StopTB_TB%20LEA%20DRAFT_FINAL_Sept%2027.pdf
- UNESCO. (2013). *Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people in Eastern and Southern Africa*. Retrieved from <https://hivhealthclearinghouse.unesco.org/library/documents/ministerial-commitment-comprehensive-sexuality-education-and-sexual-and>
- UNHCR. (2019). Kenya - Registered refugees and asylum seekers.
- United Nations General Assembly. (2011). 65/277. Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS.
- United Nations General Assembly. (2016). 70/266. Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030.
- United Nations General Assembly. (2018). Resolution A/RES/73/3 Political declaration of the High-Level Meeting of the General Assembly on the Fight Against Tuberculosis.
- USAID. (2018). *Malaria in Pregnancy Country Profile - Kenya*. Retrieved from https://www.mcsprogram.org/wp-content/uploads/dlm_uploads/2018/09/Kenya-MIPCountryProfile.pdf
- USAID. (2019). Kenya: Determined, resilient, empowered, AIDS-free, mentored and safe women (DREAMS).
- Van Der Elst, E. M., Kombo, B., Gichuru, E., Omar, A., Musyoki, H., Graham, S. M., . . . Operario, D. (2015). The green shoots of a novel training program: Progress and identified key actions to providing services to MSM at Kenyan health facilities. *Journal of the International AIDS Society*, 18(1). doi:10.7448/IAS.18.1.20226
- van der Elst, E. M., Smith, A. D., Gichuru, E., Wahome, E., Musyoki, H., Muraguri, N., . . . Sanders, E. J. (2013). Men who have sex with men sensitivity training reduces homophobia and increases knowledge among Kenyan healthcare providers in coastal Kenya. *Journal of the International AIDS Society*, 16, 18748. doi:10.7448/IAS.16.4.18748
- Vision2030. (2018). County Governments at the Centre of Achieving Universal Health Care. Retrieved from <https://vision2030.go.ke/county-governments-at-the-centre-of-achieving-universal-health-care/>
- Wanjiku Musili, L., & N. Mbatia, P. (2016). The Status of HIV/AIDS Management Strategies in Correctional Settings in Kenya: A Case Study of Lang'ata Women and Kamiti Maximum Prisons. *Sociology and Anthropology*. Retrieved from <http://www.hrpub.org/download/20160331/SA2-19605441.pdf>
- Waters, K. P., Zuber, A., Willy, R. M., Kiriinya, R. N., Waudu, A. N., Oluoch, T., . . . Riley, P. L. (2013). Kenya's Health Workforce Information System: A model of impact on strategic Human Resources policy, planning and management. *International Journal of Medical Informatics*, 82. Retrieved from <http://tarjomefa.com/wp-content/uploads/2016/03/4500-English.pdf>
- WHO. (2001). *A Human Rights Approach to Tuberculosis*. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/66701/WHO_CDS_STB_2001.9.pdf?sequence=1&isAllowed=y
- WHO. (2006). *Advocacy, Communication and Social Mobilization to Fight TB - A 10-year Framework for Action*. Retrieved from <http://www.stoptb.org/assets/documents/resources/publications/acsm/tb-advocacy.pdf>

- WHO. (2009). *A Brief History of Tuberculosis Control in Kenya*. Retrieved from World Health Organization:
https://apps.who.int/iris/bitstream/handle/10665/43934/9789241596923_eng.pdf
- WHO. (2010). *Guidance on ethics of tuberculosis prevention, care and control*. Retrieved from
https://apps.who.int/iris/bitstream/handle/10665/44452/9789241500531_eng.pdf?sequence=1
- WHO. (2015). World Health Organization. Kenya: WHO statistical profile.
- WHO. (2017a). Kenya Tuberculosis Profile.
- WHO. (2017b). *World Health Organization. World Malaria Report - 2017*. Retrieved from Geneva, Switzerland:
<https://apps.who.int/iris/bitstream/handle/10665/259492/9789241565523-eng.pdf>
- WHO. (2018). *Global Tuberculosis Report 2018*. Retrieved from
https://www.who.int/tb/publications/global_report/en/
- [WHO. \(2018a\). Seventy-first World Health Assembly Schedule of Member States' Side Events \(Advance draft\).](#)
- WHO Africa. (2018). Building Health: Kenya's Move to Universal Health Coverage. Retrieved from <https://www.afro.who.int/news/building-health-kenyas-move-universal-health-coverage>
- WOFAK. (n.d.-a). Global Fund HIV Grant Application.
- WOFAK. (n.d.-b). Global Fund TB Grant Application.
- WOTRO Science for Global Development in The Hague. (2016). *Policy Brief - Decriminalisation of sex work in Kenya*. Retrieved from https://includeplatform.net/wp-content/uploads/2016/05/VU_outline_reviewed_press.pdf