

KENYA

Progress Assessment

**Global Fund Breaking
Down Barriers Initiative**

December 2023

Table of Contents

1. Report Summary	5
1.1 Introduction	5
1.2 Summary of Investments and Implementers	6
1.3 Assessment Findings	6
1.4 HIV Component	6
1.5 TB Component	7
1.6 Malaria Component	7
1.7 Other Findings	8
1.8 Overview of Scorecard Results	9

2. Background and Country Context	10
2.1 Introduction	10
2.2 Status of the HIV epidemic	11
2.3 Status of the TB epidemic	15
2.4 Status of the malaria epidemic	16
2.5 Law and policy context	20
2.6 COVID-19	23
2.7 Investments	24
2.8 Implementation Arrangements	26

3. Towards Comprehensiveness: Achievements and Gaps in Scope, Scale and Quality	28
3.1 Progress to remove barriers to HIV services	28
(a) Eliminate stigma and discrimination in all settings	29
(b) Ensuring non-discriminatory provision of health care	39

(c)	Legal Literacy (“know your rights”)	43
(d)	Increasing access to justice	47
(e)	Ensuring rights-based law enforcement practices	60
(f)	Improving laws, regulations and policies relating to HIV and HIV/TB	64
(g)	Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity	72
(h)	Community mobilization & advocacy for HIV and TB	79
3.2	Progress to remove barriers to TB services	81
(a)	Eliminate TB-related stigma and discrimination	84
(b)	Ensuring people-centered and rights-based TB services at health facilities	88
(c)	Ensure rights-based law enforcement practices for TB	90
(d)	Improving TB-related Legal literacy (“know your rights”)	94
(e)	Increasing access to justice in the context of TB	96
(f)	Improve laws, regulations and policies related to TB	99
(g)	Community mobilization and advocacy, including community-led monitoring	101
(h)	Reducing TB-related gender discriminations, harmful gender norms and violence	108
(i)	Programs in prisons and other closed settings	110
3.3	Programmes to remove barriers to malaria services	113
(a)	Reducing gender related discrimination and harmful gender norms	113
(b)	Promoting meaningful participation of affected populations	116
(c)	Strengthening community systems for participation in malaria programs	119
(d)	Monitoring and reforming laws, policies and practices	121
(e)	Improving access to services for underserved populations	122
4.	National Ownership and Enabling Environments to Address Human Rights-related Barriers	125
5.	Key Recommendations	128
5.1	Recommendations for Programs to Reduce Barriers to HIV Services	128
5.2	Recommendations for Programs to Reduce Barriers to TB Services	133

Annex 1: Summary of Methods	140
Annex 2: List of Documents Reviewed	142
Annex 3: List of Stakeholders	143

1. Report Summary

1.1 Introduction

Since 2017, Kenya has been one of twenty countries to participate in the Breaking Down Barriers (BDB) Initiative, a ground-breaking effort of the Global Fund to Fight AIDS, Tuberculosis and Malaria ('the Global Fund') to scale up programs to reduce or remove human rights and gender-related barriers to HIV, TB and malaria services. For the 2021-2024 allocation period, Kenya received USD \$3.8 million in catalytic matching funds to scale-up its efforts to reduce or remove human rights-related barriers to HIV and TB services. This amount was fully matched from within the main 2021-2024 funding allocation request of USD 4.5 million and an additional USD 1.4 million prioritized above allocation request (PAAR)) to achieve a total investment of approximately USD 9.7 million in programs to reduce barriers. The total investment excluding PAAR is approximately USD 7.9 million.

This investment is complemented by other support under the BDB Initiative to scale up and sustain programs to reduce human rights-related barriers to HIV and TB services including: (a) support for a baseline, mid-term and this progress assessment to strengthen monitoring and evaluation and determine the impact of investments to scale up the programs; (b) support to develop and finalize the *Strategic Plan: Comprehensive response to human rights and gender-related barriers to HIV, TB and malaria services in Kenya 2021- 2024* ('the Human Rights Plan'); and (c) implementation support in the form of longer-term technical assistance.

In 2022, a Mid-Term Assessment (MTA) reviewed country progress to reduce or remove barriers since the Baseline Assessment that was conducted in 2021.¹ A little more than a year after the publication of the MTA, a follow-up Progress Assessment was undertaken during the period June to August 2023 to document and assess the country's more recent achievements, to update Kenya's scorecard and to support the development of Kenya's Global Fund Cycle 7 (GC7) funding request submission. This report sets out the findings and recommendations from the Progress Assessment. Given the relatively short period of time between the MTA and this Progress Assessment this report highlights the extent to which recommendations made in the MTA report have been implemented.

The process followed the methodology outlined by a team of researchers affiliated with Drexel University and approved by the Global Fund. The assessment for Kenya was done by a team comprised of lead researcher and one national consultant. Data collection occurred during June to August 2023 and involved key informant interviews, group discussions, document reviews and, in addition to Nairobi, site visits to Mombasa, Kilindi, Kisumu, Kakamega and Bungoma.

¹ The assessment report is available at: https://www.theglobalfund.org/media/11895/crg_2022-midtermassessmentkenya_report_en.pdf

1.2 Summary of Investments and Implementers

For the three-year, GC6 period, in addition to its overall allocation of US\$441 million for HIV, TB and malaria programs, Kenya received US\$4 million in matching, catalytic funds to scale up programs to reduce human rights barriers to HIV and TB services. A total amount of \$ 7.9 million was budgeted for addressing human rights and gender-related barriers to HIV, TB and malaria services within the Global Fund grant allocation and through Matching Funds.

Of the funds for programs to reduce barriers and for CSS, non-state actors KRCS and AMREF were allocated 86% (USD 9,634,138) of the total to support non-governmental and civil society partners. The remaining proportion was allocated under the National Treasury to support public sector efforts to reduce barriers.

1.3 Assessment Findings

The findings of the assessment make clear that over the 2021-2023 period, Kenya made important progress to scale up programs to reduce barriers to HIV, TB and malaria services. Progress was also achieved to reduce human rights-related barriers in a number of program areas, with consequent improvements in uptake and retention in services. This was more apparent for the HIV program than for the TB and malaria programs, however.

1.4 HIV Component

In most program areas for HIV, there was good progress to scale up interventions to reduce barriers, largely as a result of increased investments under the GC6 allocation, but also through contributions of other donors and partners. All of the program areas scored higher in this assessment than in the MTA. Training of HIV and TB stakeholders and key and vulnerable population led networks to carry out legal literacy using peer educators and paralegals has been scaled up, as have legal literacy programs implemented by KP-led organizations. Access to justice has been improved through the scale up of peer paralegal programs and access to pro bono lawyers. An innovative approach to capacity strengthening for KP peer paralegals was identified in the form of on the job mentoring of paralegals by lawyers with a view to making the paralegals more self-sufficient in respect of legal assistance by building their skills to handle matter that are referred to them on their own rather than referring all cases on to pro bono lawyers.

Efforts to eliminate HIV-related stigma and discrimination in Kenya address all six settings recommended by the Global Partnership for Action to End all Forms of HIV-related Stigma and Discrimination, but with varying degrees of focus and effectiveness. The most progress was noted in the employment and education sectors. There have also been increased efforts to address internalized stigma. The tabling of the Family Protection Bill has however seriously exacerbated stigma, discrimination and violence against MSM and transgender people.

Less progress was achieved with regard to ensuring rights-based law enforcement practices, due in part to the fact that HIV, TB and human rights training is yet to be incorporated in the pre-service training curriculum for the Kenya Police Service. Law

and policy change has regrettably retrogressed with the tabling of the Family Protection Bill which further criminalizes same sex sexual relationships that has and will continue to create severe barriers to access to services for MSM and TG, in addition to increasing threats to their safety and security.

1.5 TB Component

With regard to TB, there was a smaller degree of program scale up, but all nine program areas scored higher in this assessment than in the MTA. To a large degree, efforts to remove barriers to TB services leveraged HIV investments through the integration of TB-related topics in these interventions, albeit with perceived lesser attention being paid to TB than to HIV. Key informants interviewed for this assessment indicated that levels of TB-related stigma and discrimination in communities remains high. One key informant remarked as follows: “People easily say “When I had COVID...” but you never hear people saying “When I had TB....” You will also never hear TB being mentioned in a eulogy.”² There has however been substantial progress made on programming to reduce TB-related stigma and discrimination particularly in the education and employment sectors. An initial TB Gender Assessment conducted in 2018 found that the impact of culture and gender on access to TB services needs to be investigated in all 47 counties, given cultural differences across counties, to better understand the impacts of gender on accessing TB services in Kenya. A Community Rights and Gender (CRG) assessment as well as TB stigma assessment will be undertaken before the end of 2023, and the results used to inform programming to reduce TB-related gender discrimination. Substantial progress has been made in programming for community mobilization and advocacy since the MTA, including through institutional capacity building, planning and leadership development, social mobilization, building community linkages and coordination, community-led advocacy and research and CLM.

1.6 Malaria Component

There has been some progress made on the implementation of programs to address human rights and gender related barriers to access to malaria services, with two of the five program areas scoring higher in this assessment than in the MTA.

A malaria matchbox assessment³ was conducted in 2022 that identifies specific strategies to reduce gender-related barriers and harmful gender norms. The report identified pregnant women and children under the age of 5 as being the primary groups being left behind in terms of malaria prevention and treatment. In addition, the assessment reported that access by pregnant women to ANC services is often hampered by power dynamics in relationships in terms of which men control women’s access to health services. In addition, the teenage pregnancy rate is relatively high⁴ and pregnant teenagers face negative societal perceptions regarding early pregnancies and avoid health facilities for fear of stigmatisation. The current National Malaria Strategy, which has adopted HRG as a guiding principle comes to an end in

² Key informant interview with Stop TB representative 30 May 2023.

³ An equity assessment tool, designed to support the identification of populations or individuals most affected by malaria and underserved by malaria interventions, as well as the key equity- human rights- and gender-related barriers disproportionately affecting malaria outcomes in those populations

⁴ The KDHS 2022 reported the teenage pregnancy rate as 15%

December 2023. A new malaria strategy is to be developed once the malaria sector plan review is finalised, which will incorporate and be guided by the findings and recommendations from the matchbox assessment. The National Malaria Program has placed a high priority on integrating gender and human rights perspectives, as well as emphasizing community engagement in the implementation of the Malaria Matchbox findings in the GC7 Global Fund Malaria Funding Request.

KeNAAM completed a mapping of Kenya CSOs working on Malaria, HIV and TB in 2022. Most of the CSO's respondents are working with communities in informal settlements (23%), followed by Persons with Disabilities (19%), indigenous communities (16%), fishing communities (13%), hard to reach populations and prisons (6% each), and refugees (3%). Only a small portion of the CSO respondents is covering all the KVP (6%)⁵.

Capacity building interventions with CSOs working in the malaria sector are ongoing to enhance their capacity to participate in policy design and monitoring of implementation. In addition, community health promoters are being trained to provide access to medicine and diagnostics for vulnerable groups e.g. the fishing community and seasonal workers who face challenges, such as lack of protection and sleeping space⁶. This assessment identified a number of ongoing gaps and challenges in respect of reaching underserved populations, including fisherfolk and people who move around for the purposes of work including seasonal workers and truckers. Work to reach underserved populations needs to be scaled up substantially.

1.7 Other Findings

From the assessment findings, it was apparent that there is improvement in national ownership for reducing or removing human rights- and gender-related barriers to HIV, TB and malaria services as evidenced by the adoption of the *Kenya AIDS Strategic Framework (KASF II) (2020/2021 - 2024/2025)*, as well as the *National Strategic Plan for Tuberculosis, Leprosy and Lung Health 2019-2023*. ('the TB NSP'), and the *Kenya Malaria Strategy 2019-2023*, all of which have a strong emphasis on the removal of human rights and gender related barriers⁷. In addition, the country's clear commitment to reducing human rights and gender related barriers to HIV, TB and malaria services is outlined in the *Strategic Plan: Comprehensive response to human rights and gender-related barriers to HIV, TB and Malaria services in Kenya (2021-2024)*. The aim of the Human Rights Plan is to provide a supportive, human rights-based and gender-transformative policy environment for the implementation of HIV, TB and malaria programs that reduce new infections, AIDS, TB and malaria related deaths and discrimination against people living with HIV and other key and vulnerable populations in the context of HIV, TB and malaria. This plan has been developed to set out a comprehensive integrated response to human rights and gender related barriers to HIV, TB and malaria services in Kenya, as well as a monitoring and evaluation framework, which will facilitate better coordination and strategizing for the

⁵ Mapping report p17

⁶ Key informant interview National Malaria Program representative 20 June 2023

⁷ See para 2.5 above for further details on these plans.

effective scale-up of programs to remove human rights and gender-related barriers to an effective HIV, TB and Malaria response.

A significant shortcoming across the board however is the lack of a monitoring and evaluation system that is capable of tracking outcomes of human rights and gender programming and thus makes it difficult to track progress in terms of the impact of current programming to reduce human rights and gender related barriers to access to HIV, TB and malaria services.

1.8 Overview of Scorecard Results

The scorecard results by disease component and program area are shown below⁸.

HIV component

Program Area	Baseline (2021)	MTA (2022)	Progress (2023)
Eliminate stigma and discrimination in all settings	2.0	3.5	4.0
Ensure non-discriminatory provision of health care	2.0	2.5	2.7
Ensure rights-based law enforcement practices	2.0	3.0	3.3
Improve legal literacy ("know your rights")	1.0	2.5	3.6
Improve access to justice (HIV-related legal services)	2.5	3.5	4.0
Improve laws, regulations and policies related to HIV and HIV/TB	3.0	4.0	4.3
Reducing HIV-related gender discrimination	2.0	2.5	3.6
Community mobilization and advocacy for HIV/TB	*	*	3.0
Average Score	2.1	3.1	3.6[#]

[#]: Note that the average scores only consider the first seven indicators so as to ensure consistency.

TB component

Program Area	Baseline (2021)	MTA (2022)	Progress (2023)
Eliminate TB-related stigma and discrimination	3.0	3.0	3.6
Ensure people centered and rights-based TB services at health facilities	1.0	2.0	2.3
Ensure rights-based law enforcement practices	1.0	1.5	2.0
Improve TB-related legal literacy ("know your rights")	*	1.5	2.0
Improve access to justice in the context of TB	*	1.5	2.3
Improve laws, regulations and policies related to TB	1.5	2.0	3.3
Community mobilization and advocacy, including CLM	2.0	3.0	4.0
Reduce TB-related gender discrimination	0.5	1.0	2.0
Programs in prisons and other closed settings	1	1.5	2.0

⁸ See Annex 1 for interpretation of scores

Average Score	1.4^{##}	1.8^{##}	2.6
----------------------	-------------------------	-------------------------	------------

^{##}: Note that the average scores for baseline and mid-term take into account ten program areas, the nine shown above plus “Ensuring confidentiality and privacy” that was removed from the progress assessment.

Malaria component

Program Area	Baseline (2021)	MTA (2022)	Progress (2023)
Reducing gender related discrimination and harmful gender norms	0	0.5	1.0
Promoting meaningful participation of affected populations	0.5	1.5	2.0
Strengthening community systems for participation in malaria programs	*	2.0	2.0
Monitoring and reforming laws, policies and practices	*	*	0
Improving access to services for underserved populations	1.0	1.0	1.0
Average Score	0.8*	1.3*	1.2*

*Note that the average scores for baseline and mid-term take into account 5 program areas, where “malaria programs in prisons and pre-trial detention” was included. In the progress assessment, this program area was incorporated into “Improving access to services for underserved populations”, and a new program area “Monitoring and reforming laws, policies and practices” was added.

2. Background and Country Context

2.1 Introduction

Since 2017, Kenya has been one of twenty countries to participate in the Breaking Down Barriers (BDB) Initiative, a ground-breaking effort of the Global Fund to Fight AIDS, Tuberculosis and Malaria (‘the Global Fund’) to scale up programs to reduce or remove human rights and gender-related barriers to HIV and TB services. For the 2021-2024 allocation period, Kenya received USD \$3.8 million in catalytic matching funds to scale-up its efforts to reduce or remove human rights-related barriers to HIV and TB services. This amount was fully matched from within the main 2021-2024 funding allocation request of USD 4,5 million and an additional USD 1.4 million prioritized above allocation request (PAAR)) to achieve a total investment of approximately USD 9.7 million in programs to reduce barriers. The total investment excluding PAAR is approximately USD 7.9 million.

This investment is complemented by other support under the BDB Initiative to scale up and sustain programs to reduce human rights-related barriers to HIV and TB services including: (a) support for a baseline, mid-term and this progress assessment to strengthen monitoring and evaluation and determine the impact of investments to scale up the programs; (b) support to develop and finalize the *Strategic Plan: Comprehensive response to human rights and gender-related barriers to HIV, TB and malaria services in Kenya 2021- 2024* (‘the Human Rights Plan’); and (c) implementation support in the form of longer-term technical assistance.

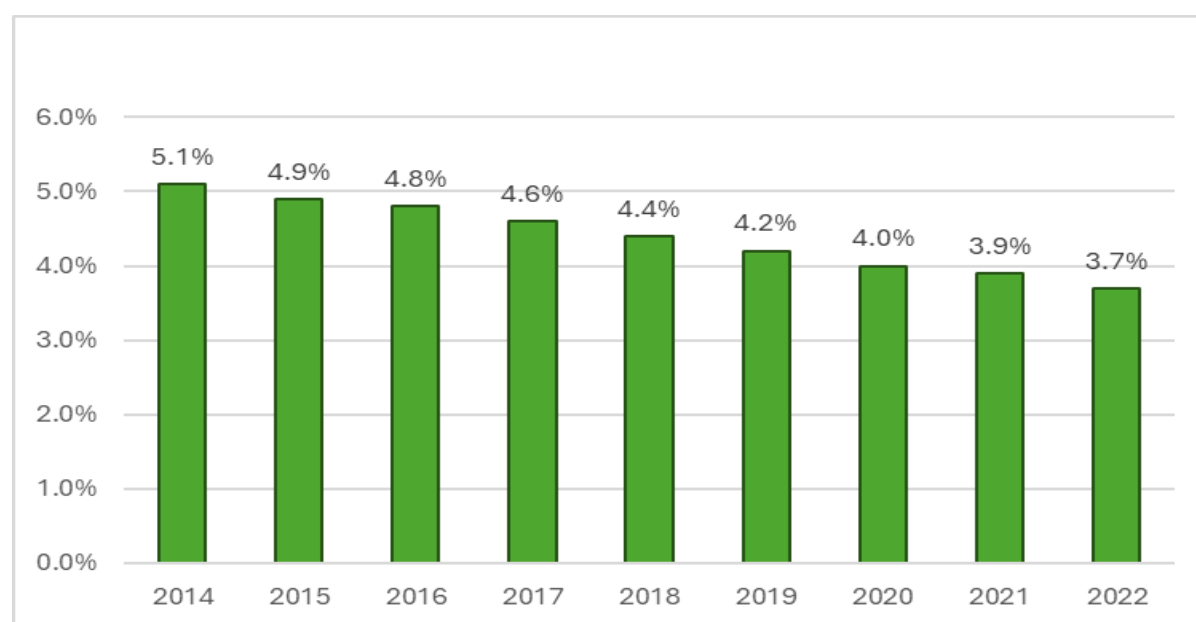
In 2022, a Mid-Term Assessment (MTA) reviewed country progress to reduce or remove barriers since the 2021 Baseline Assessment.⁹ During the period June to August 2023, a follow-up Progress Assessment was undertaken to document and assess the country's more recent achievements, to update Kenya's scorecard and to support the development of Kenya's Global Fund Cycle 7 (GC7) funding request submission. This report sets out the findings and recommendations from the Progress Assessment.

By August 2023, the Ministry of Health (MOH), along with its partners and stakeholders, had continued to take important steps to address and mitigate the health and social impacts of the interlinked epidemics of HIV and TB as well as of malaria. The country remained committed to ending these as public health threats to the population by 2030. A brief overview of the status of the HIV and TB epidemics is given below to set the context for the Progress Assessment.

2.2 Status of the HIV epidemic

Kenya had an estimated 1,400,000 people living with HIV (PLHIV) (all ages) in 2022. This equates to an HIV prevalence of 3.7% among the adult population (Figure 1). HIV prevalence among children (less than 15 years) was 0.7% which translates to approximately 68,000 children living with HIV in Kenya. As is elsewhere in the region women experience a disproportionate HIV burden throughout the life cycle whose HIV prevalence is two times greater than their male peers (4.9% compared to 2.4%).

Figure 1: Trends in HIV prevalence in Kenya, 2014-22 (2023, HIV estimates)



There is a huge variation in HIV prevalence across geographies, with the counties in western Kenya having higher prevalence compared to the rest of the country. Prevalence varies across regions from 10.4% in Nyanza region to a low of 0.2% in

⁹ The assessment report is available at: https://www.theglobalfund.org/media/11895/crg_2022-midtermassessmentkenya_report_en.pdf

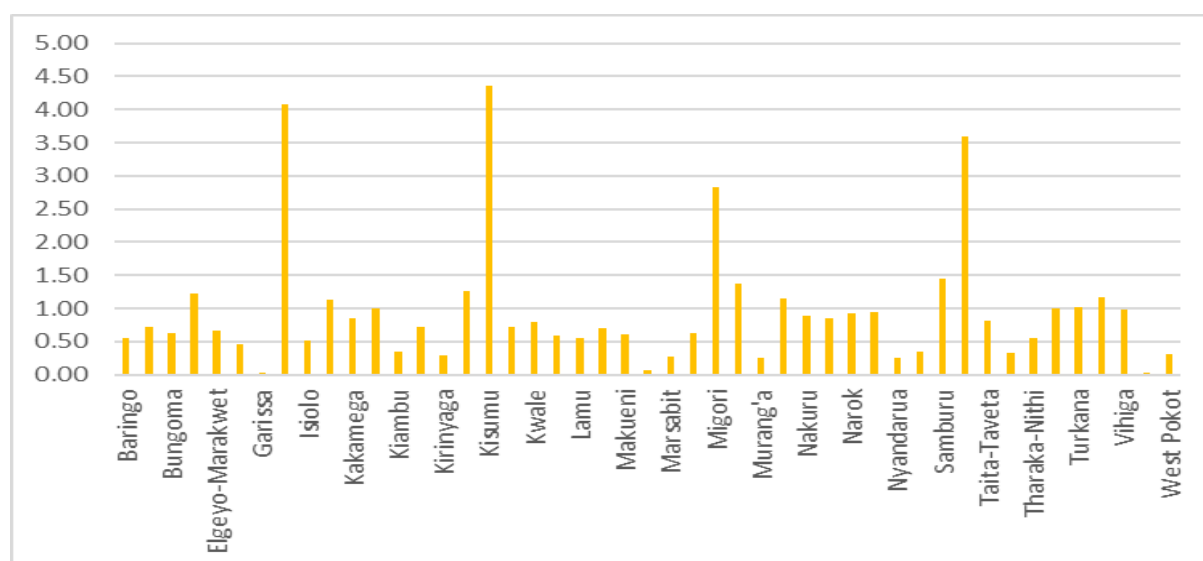
Northeastern. Within regions, HIV prevalence varies from a high of 15.2% in Homa Bay to a low of 0.1% in Wajir and Garissa counties.

Available data suggests that HIV prevalence rates among key populations range from 4.8% to 16% among female sex workers; 8.3% among MSM; 25% among Transgender and 19.7% among People who inject Drugs (PWID).

New HIV infections have declined by approximately 21% from 28,000 in 2018 to 22,000 at the end of 2022. The Kenya HIV Estimates 2022, show that Adolescents and Young People (AYPs) aged 15-24 contribute about 33% of adult new infections with new infections among Adolescent Girls and Young Women (AGYW) significantly higher (5,700 in 2022) than boys (1,600 in 2022) of the same age group.

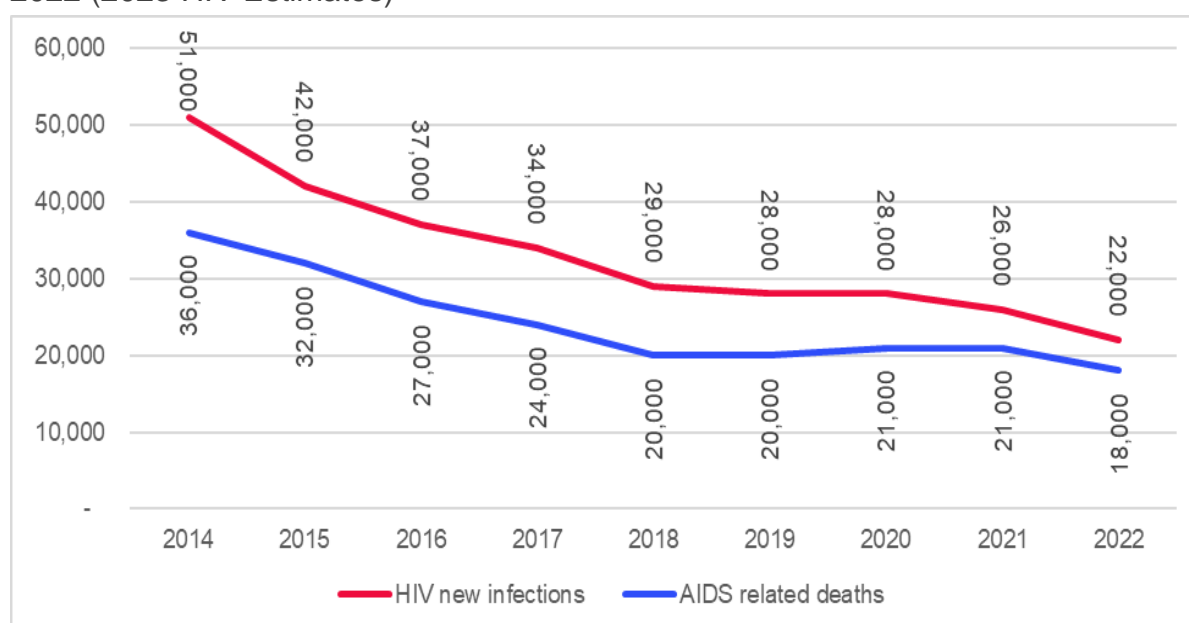
HIV incidence rates vary across different counties from 4.36 in Kisumu to 0.022 in Wajir and Garissa.

Figure 2: HIV incidence across counties in Kenya (2023, HIV estimates)



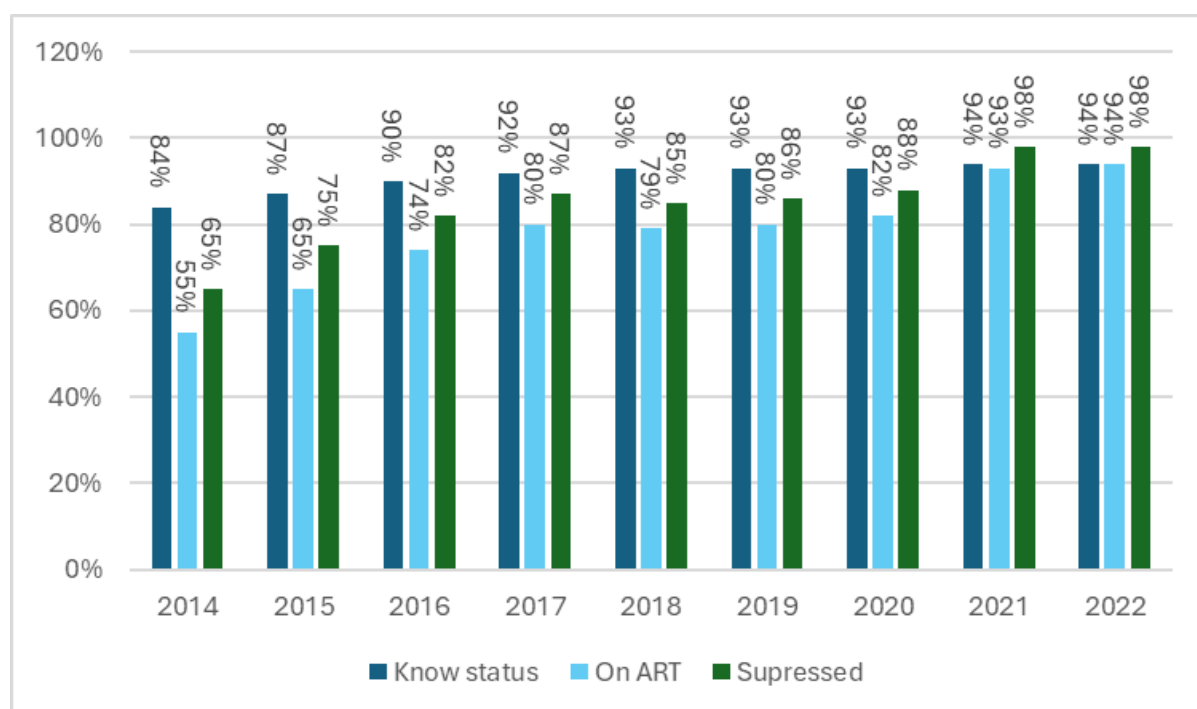
In total there have been 219,000 AIDS related deaths between 2014 and 2022 (Figure 3) but as can be seen from the figure below, there has been a 50% decline in annual mortality from 36,000 deaths in 2014 to 18,000 at the end of 2022.

Figure 3: Trends in new HIV infections versus AIDS related deaths in Kenya, 2014 – 2022 (2023 HIV Estimates)



Kenya has made significant progress towards the 95-95-95 targets. The overall cascade shows that 94% of PLHIV know their HIV status; 94% of PLHIV are currently on ART and 98% of PLHIV on ART have achieved Viral suppression – Figure 4. However, for Children 0-14 years, only 85% of those living with HIV know their status, with 98% on ART and only 88% of those on ART achieve viral suppression.

Figure 4: 95-95-95 cascade 2014-2022 in Kenya (2023 HIV Estimates)



TB-HIV: TB remains the leading cause of death among people living with HIV in Kenya. In 2022, TB deaths among HIV-positive people accounted for 11% of all TB deaths (among HIV-negative and HIV-positive people) representing an enormous burden of preventable deaths and ill-health. TB symptom screening among PLHIV is 90% nationally with extremely low yield (2%). It is estimated that 50% of HIV co-infected TB cases were missed nationally in 2022. 93% of notified TB patients nationally had a documented HIV test result in 2022, down from 97% in 2021. Levels of coverage vary significantly by county, with ASAL counties reporting significantly lower rates (ranging between 70 to 90%).

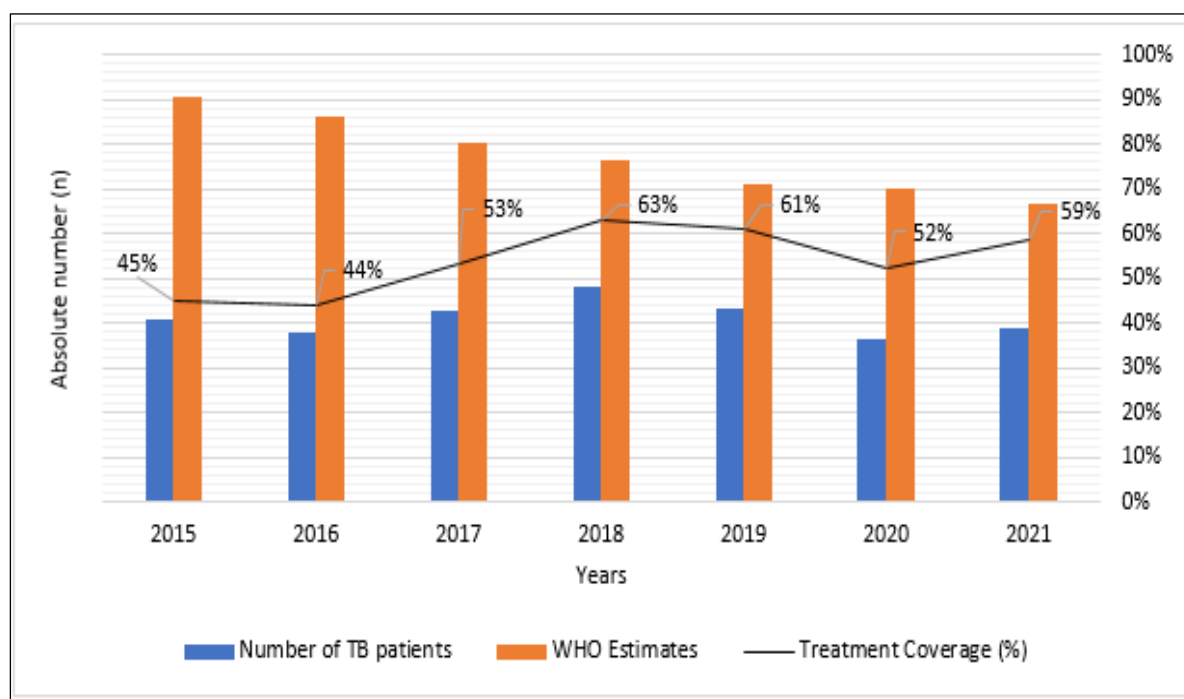
Among HIV-positive TB patients notified by NTLP 97% were on ART nationally at the end of 2022, a slight reduction compared with 97.8% in 2021. There remains a substantial gap between the number of HIV-positive TB patients started on ART, and the estimated total number of HIV-positive people with TB who need both TB treatment and ART. Further, the TSR for the TB/HIV co-infected patients was 78.6% significantly below the national and grant target of 90 and lower than the treatment success rate for HIV-negative TB patients (86%). Because of suboptimal ART coverage and poor TSR, TB/HIV case fatality rate is quite high at 11% vs 4% for HIV negative TB patients.

The uptake of TPT among PLHIV stood at 88% with completion rates at 84% at the end of 2022 up 20% from when the current funding request was prepared. TPT uptake among the newly enrolled PLHIV was even lower at 34% in 2022. As with routine testing, Levels of coverage vary significantly by county, with ASAL counties reporting significantly lower rates. There were no gender or age differences in the uptake of TB/HIV interventions.

2.3 Status of the TB epidemic

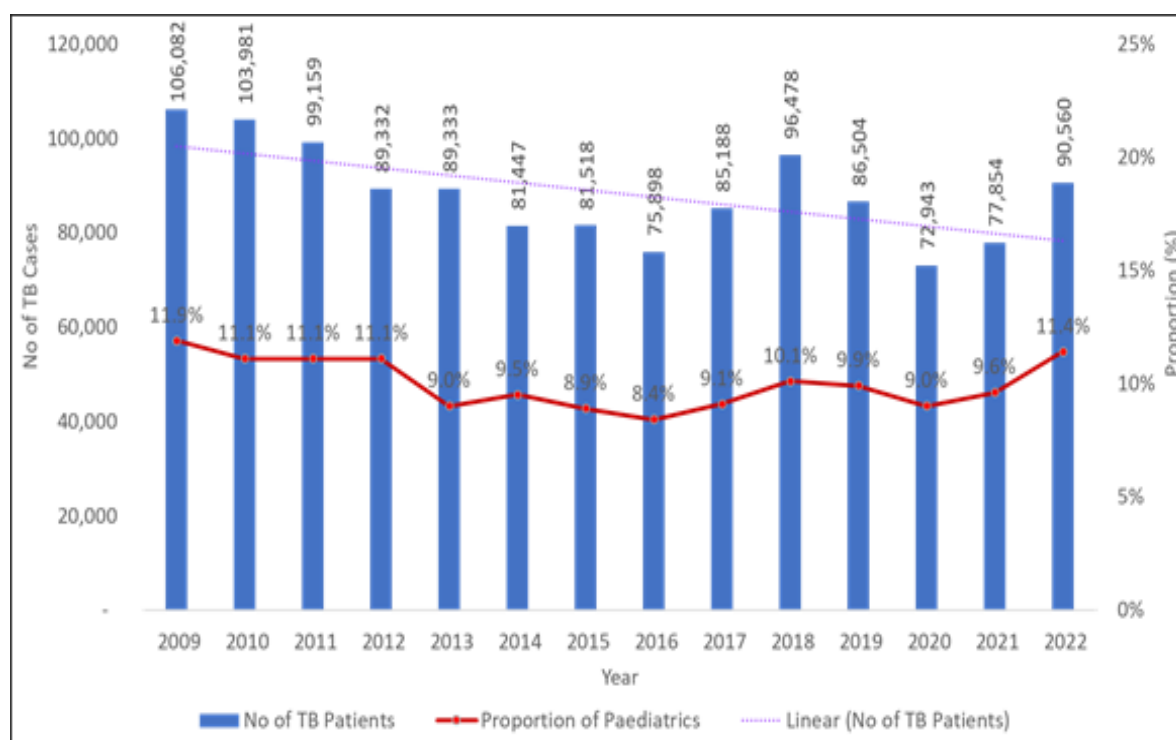
There has been a continuous decrease in TB incidence from 181,151 TB patients in 2015 to 140,275 in 2020 and further to 133,000 in 2021. According to the WHO Global TB Report, 2021 Kenya was one of the high TB burden countries that achieved WHO's End TB Strategy milestone for 2020 with a 32% reduction in TB incidence compared to 2015, against a target of 20%. The country also achieved a 44% reduction in the number of TB deaths compared to 2015, exceeding the target of 35%.

Figure 5: Changes in TB treatment coverage between 2015 and 2021



Despite these achievements, the country's treatment coverage gap remains wide at nearly 50% of unreached people with TB in 2021. There has however been an upward trend with the estimated TB treatment coverage increasing from 52% in 2020 to 59% in 2021 according to the WHO Global Report 2022, and as shown in Figure 5 above. Similarly, TB notifications show an upward trend from 72,943 in 2022 to 90,560 in 2022 (Figure 6). The increase could reflect a recovery of TB services following disruption brought about by the COVID-19 pandemic. The number of children with TB notified in the country is also seen to be increasing, from 9% in 2020 to 11.4% in 2022 as shown in figure 6 below.

Figure 6: Trend of TB patients notified between 2009 and 2022



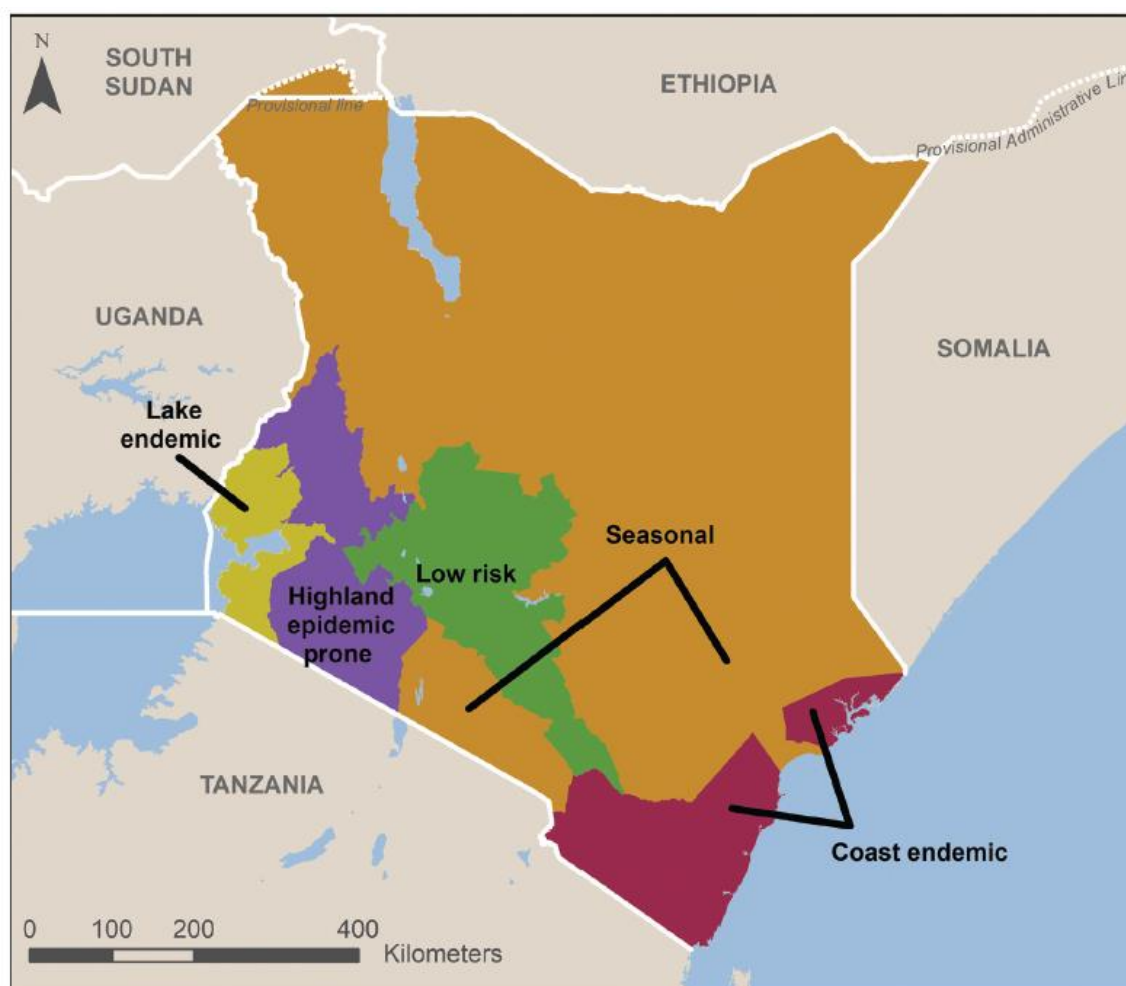
Data source: DNTLD-P, MOH

Drug resistant TB remains a significant public health issue in Kenya as demonstrated by the increase in the number of DR TB patients notified over the years. There has however been a decrease in the number of notified DR-TB patients from 957 in 2020 to 756 in 2022.

2.4 Status of the malaria epidemic

Kenya has made significant progress in the fight against malaria over the past decade, achieving an almost 50 percent reduction in malaria prevalence both nationally and in the lake endemic counties where the burden is highest¹⁰. Across Kenya, malaria risk is heterogeneous, and its epidemiology is influenced by altitude, rainfall patterns, and temperature. Therefore, malaria prevalence varies considerably by season and across geographic regions. The country is divided into six malaria transmission areas. Busia and Siaya are high transmission counties in Western Kenya with a plasmodium falciparum parasite prevalence (PAPfPr) greater than 30 percent. Bungoma, Kakamega, Kisumu, and Migori, all in Western Kenya, are moderate transmission counties, with a PAPfPr between 10–30 percent. Vihiga in Western Kenya, Mombasa at the coast, and Turkana in northwestern Kenya are low to moderate transmission counties, with a PAPfPr ranging from 5–10 percent. Homa Bay in Western Kenya, and Kilifi and Kwale counties at the coast, are low transmission counties, with a PAPfPr in this zone is between 1–5 percent. Finally, the remaining 35 counties fall into the category of very low transmission, with a PAPfPr below 1 percent.

¹⁰ Kenya Malaria Indicator Surveys [MIS], 2020



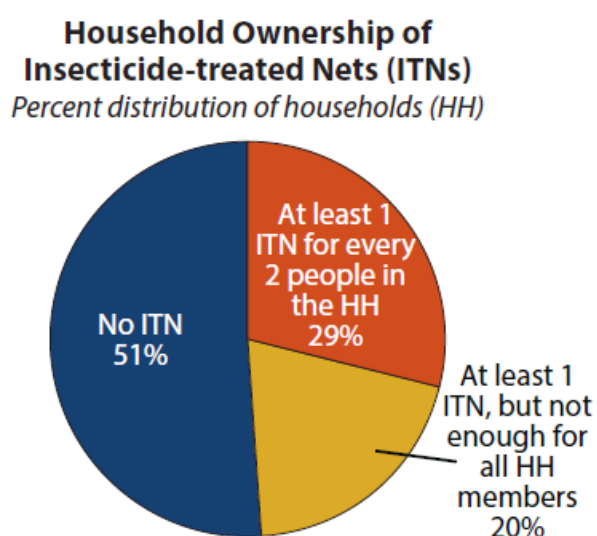
Source: Kenya Malaria Indicator Survey 2020

Despite significant progress, malaria remains a major public health problem in Kenya and accounted for an estimated 6 percent of outpatient consultations in Kenya in 2021 (Ministry of Health [MOH] Kenya, 2022). The Kenya MISs indicated that the national prevalence of malaria among children younger than five years of age decreased from 8 percent in 2015 to 6 percent in 2020. This decline was driven by decreases in the high burden lake endemic counties. In this endemic zone, the prevalence of malaria among children younger than five years of age decreased from 27 percent to 19 percent during the same period. Prevalence based models incorporating data from MISs, school surveys, and malaria vaccine and climate data for 2000 through 2020 suggest that the counties in the lake endemic zone have transitioned from high malaria transmission to low to moderate malaria transmission. Routine data from the Kenya Health Information System (KHIS) demonstrate that the annual incidence of diagnostically confirmed malaria cases in the outpatient setting also decreased, from 113 per 1,000 population in FY 2016/17 to 79 per 1,000 population in FY 2020/21. Nationwide, prevalence models based on the 2020 MIS and other data sources suggest that only 30 percent of the country's population lives in an area with a malaria prevalence over 1 percent; this represents a significant reduction from the 2015

Malaria Indicator Survey (MIS), after which 75 percent of the population lived in counties with malaria prevalence over 1 percent¹¹.

Access to and uptake of malaria prevention has declined. Among households in Kenya, 49% own at least one insecticide-treated net or ITN. An ITN is a factory-treated net that does not require any further treatment. ITN ownership has declined since 2015 when 63% of households owned at least one ITN.

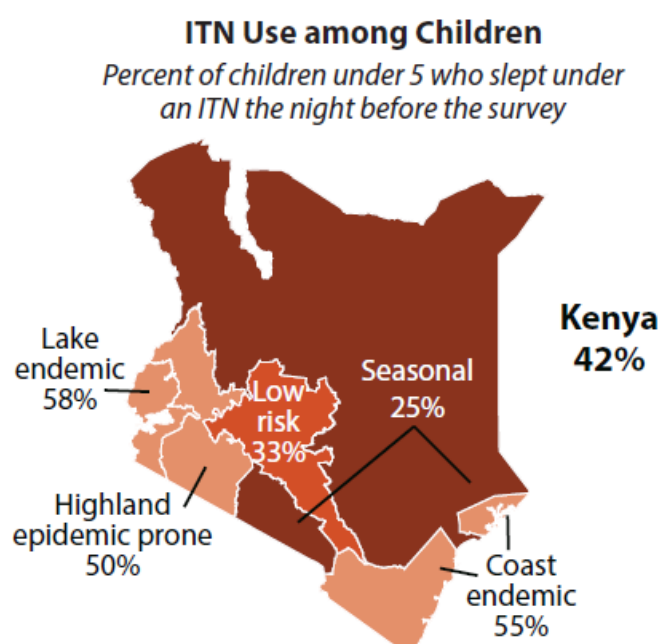
Only 29% of households have enough ITNs to cover each household member, assuming one ITN is used by two people. One in five households have at least one ITN but not enough for all household members, while half of households do not have an ITN.



Source: Kenya Malaria Indicator Survey 2020

Children under 5 and pregnant women are the groups most vulnerable to malaria. Forty-two percent of children under 5 and 40% of pregnant women slept under an ITN the night before the survey. By endemicity zone, ITN use among children ranges from 25% in Seasonal zone to 58% in Lake endemic zone. Use of ITNs by both children and pregnant women has decreased since 2015. Among households that own an ITN, 72% of children under 5 and 73% of pregnant women slept under an ITN the night before the survey.

¹¹ U.S. PRESIDENT'S MALARIA INITIATIVE Kenya Malaria Operational Plan FY 2023



Source: Kenya Malaria Indicator Survey 2020

Malaria during pregnancy contributes to low birth weight, infant mortality, and other complications. To prevent malaria, pregnant women living in malaria-endemic areas in Kenya should receive 3+ doses of SP/Fansidar during their pregnancy. In Kenya, 38% of pregnant women received at least 1 dose of this intermittent preventive treatment, or IPTp, while 30% of women received 2+ doses and only 22% received 3+ doses. Uptake of IPTp 1+ and IPTp 2+ have declined since 2015, while uptake of IPTp 3+ has stagnated. The Kenya National Malaria Strategy targets IPTp interventions to women living in malaria-endemic areas. Among pregnant women living in IPTp targeted malaria endemic areas, 49% in Lake endemic zone and 46% in Coast endemic zone received 3+ doses of IPTp. Urban women and those from the poorest households are least likely to receive IPTp 3+ among women in Coast endemic and Lake endemic zones.

Women who only received one or two doses of IPTp were asked why they did not complete the treatment. Forty-one percent said they were not given the treatment and 35% were unaware they had to take more.

Fever is a major symptom of malaria in children. In Kenya, mothers were asked if their children had any fever during the 2 weeks before the survey and if they sought medical help. Overall, 17% of children under 5 had a fever in the 2 weeks before the survey.

Nearly two-thirds (64%) of children with recent fever had advice or treatment sought, a slight decrease from 72% in 2015. Sixty-five percent of rural children with recent fever had advice or treatment sought, compared to 60% of urban children. Nearly 40% of children with recent fever had advice or treatment sought the same or next day. Among children with recent fever for whom advice or treatment was sought, 68% received care from the public sector, 32% from the private sector, and 2% from other private sector sources.

Overall, 85% of women aged 15-49 know ways to avoid getting malaria. Nearly all women (94%) know sleeping under an ITN prevents malaria. Other commonly reported ways to avoid malaria include keep surrounding clean (26%) and fill in stagnant waters (21%).

Among women who know how to avoid getting malaria, 29% know that ACT/AL is the recommended treatment for malaria. Nearly 6 in 10 women do not know the recommended treatment for malaria¹².

2.5 Law and policy context

The Kenya AIDS Strategic Framework (KASF II) (2020/2021 - 2024/2025) provides the strategic directions that will lead to accelerated progress towards a Kenya free of HIV infections, stigma and AIDS related deaths. Premised on the provisions of the Constitution, which provides for the rights to equality and freedom from discrimination as well as to the highest attainable standard of health for all, KASF II recognizes that:

- (a) progress in elimination of HIV related stigma and discrimination is off track
- (b) PLHIV as well as specific groups, such as key populations, continue to face stigma and discrimination even in health care settings; and
- (c) there is need to address policy and legal barriers that impact negatively on access to HIV services¹³.

In addition, KASFII recognizes the links between HIV and gender inequality and that in recent decades, incremental gains towards gender equality have fallen short of improving educational and economic opportunities for women and girls, as a result of which women and girls remain disproportionately affected by poverty, violence and injustice that make them vulnerable to HIV¹⁴.

Thematic area 3 of KASFII focuses on human rights and seeks to “Protect the rights of people to live a life free of violence, stigma and discrimination through the following strategic focus areas:

- Promote accountability and responsiveness for enhanced human rights protection;
- Promote access to justice through public awareness of legal frameworks and redress institutions;
- Institutionalize progress monitoring of HIV related stigma and discrimination and other health and human rights violations; and
- Reduce all forms of violence among vulnerable priority groups.¹⁵

In addition to KASFII, Kenya has a strong laws and policies that are intended to uphold the rights of people living with HIV and key and vulnerable populations. The *Kenya National Patients’ Rights Charter*, for example, enumerates patients’ rights to the highest attainable standard of health, privacy and confidentiality, preventative care and

¹² Kenya Malaria Indicators Survey 2020

¹³ Ministry of Health and NACC. (2020) *Kenya AIDS Strategic Framework II 2020/21-2024/25 Sustain Gains, Bridge Gaps and Accelerate Progress*. (KASFII), p11

¹⁴ *ibid*

¹⁵ KASFII at p 5

treatment, and reproductive health and well-being¹⁶, while the *Health Act* similarly guarantees the right to the highest attainable standard of health including for “vulnerable groups” such as women, the elderly, persons with disabilities, children and youth, “members of minority or marginalized communities, and members of particular ethnic, religious, or cultural communities,” as well as rights to information, informed consent, confidentiality and reproductive health care¹⁷.

The *HIV and AIDS Prevention and Control Act* further enshrines protections for people living with and affected by HIV, including prohibitions on compulsory HIV testing as a precondition for employment, marriage, travel, access to health services and insurance and on HIV-related discrimination, as well as rights to voluntary, informed consent to HIV testing and to confidentiality of test results, HIV status and medical records¹⁸.

The national TB response in Kenya is guided by the *National Strategic Plan for Tuberculosis, Leprosy and Lung Health 2019-2023*. The Plan identifies strategic interventions to ensure a rights-based approach to TB management and care, including programs to sensitize lawmakers, law enforcement and health care workers on legal, health and human rights aspects of TB, reduce stigma and discrimination, promote legal literacy, provide legal services for those who have experienced human rights violations, promote laws and policies that prohibit TB-related discrimination and support TB prevention, treatment, care and support, develop tools to monitor rights violations, and integrate TB services into reproductive maternal and child health services¹⁹. Section 27 of the *Public Health Act*²⁰ (1921) permits medical providers to remove and confine a person with TB by an order of a magistrate until the medical provider is convinced that the confined person is free of TB and section 28 provides for the penalty for exposure to infectious substance. These two sections have been used to incarcerate TB patients in prison for “failure to adhere” to TB treatment.

In response to this KELIN filed a constitutional petition (Petition 329 of 2014) in 2014 to challenge the unlawful and unconstitutional incarceration of TB Patients. KELIN argued that the manner and conditions of the incarceration endangered the health of the patients and prison population. 24 March 2016, the High Court of Kenya declared that the practice of confining patients suffering from TB in prison facilities for the purposes of treatment under section 27 of the Public Health Act a violation of the Constitution and unlawful.

The Court ordered the Government to issue a circular to public health officers to the effect 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 involuntary confinement of persons suffering from infectious diseases (TB included) and that this policy should be in line with international standards²¹.

As a result, Kenya’s National Tuberculosis, Leprosy and Lung Disease Program (NTLD) developed a policy in 2018 prohibiting the confinement of patients suffering

¹⁶ Kenya National Patients’ Rights Charter, 2013.

¹⁷ The Health Act No. 21 of 2017

¹⁸ HIV and AIDS Prevention and Control Act, 2006 (No. 14 of 2006)

¹⁹ Ministry of Health. (2019). *National Strategic Plan for Tuberculosis, Leprosy and Lung Health 2019-2023*.

²⁰ Public Health Act, Cap 242, Laws of Kenya

²¹ KELIN. Tuberculosis: An Assessment of the Legal Environment in KENYA, 2018

from “infectious diseases” in prison facilities and requiring isolation to be a measure of last resort. In instances when isolation is necessary, isolation should respect human rights, be non-discriminatory, and never be imposed as a form of punishment.²²

The *Kenya Malaria Strategy 2019-2023* describes “Guiding Principles” that affirm health as a basic right and confirms a commitment to “ensuring universal access to malaria interventions among all members of the community, including the vulnerable, marginalized, and special groups” and implementation of malaria interventions “to ensure gender equity and responsiveness.”²³

Several bodies have also been created to address human rights violations, including the Kenya National Commission on Human Rights and the National Gender and Equality Commission, which were established under the Kenyan Constitution to investigate and provide redress for human rights violations. Specific to HIV, the *HIV and AIDS Prevention and Control Act* (HAPCA) established the HIV and AIDS Tribunal to improve access to justice for people living with HIV. The Tribunal has the authority to receive evidence, hear witness accounts, conduct hearings, and pass judgment on all matters arising out of any breach of the provisions of the HAPCA. Correspondingly, the 2016 *Legal Aid Act* established the National Legal Aid Service, which seeks to provide access to legal representation and counsel for civil, criminal, constitutional or public interest matters to those who cannot afford legal services²⁴.

The country’s clear commitment to reducing human rights and gender related barriers to HIV services is outlined in the *Strategic Plan: Comprehensive response to human rights and gender-related barriers to HIV, TB and Malaria services in Kenya (2021-2024)*. The aim of the Human Rights Plan is to provide a supportive, human rights-based and gender-transformative policy environment for the implementation of HIV, TB and malaria programs that reduce new infections, AIDS, TB and malaria related deaths and discrimination against people living with HIV and other key and vulnerable populations in the context of HIV, TB and malaria.

In 2022, the Global Fund-supported Kenya Mid-Term Assessment found implementation and enforcement of the legal framework remained weak or inconsistent and is impeded by barriers to accessing justice. Punitive laws that discriminate against key populations and criminalize HIV exposure and transmission, non-reporting of a person infected with TB and TB exposure, living on the earnings of and soliciting sex work, the sale of sterile injection equipment, and same sex sexual relationships fuel stigma, discrimination and violence against key populations, undermine trust in health services, and create barriers to accessing health services. Police have been reported to engage in abusive practices against key populations, including harassment, extortion, arbitrary arrest, and physical and sexual violence, and have also failed to adequately provide protection in times of need²⁵. Unfortunately, the situation remains the same at the time of this progress assessment and has been exacerbated by the recent tabling of the Family Protection Bill that further criminalizes same sex sexual relationships that has and will continue to create severe barriers to

²² Ministry of Health, National Tuberculosis, Leprosy and Lung Disease Program. (2018). *Tuberculosis Isolation Policy*.

²³ Ministry of Health and National Malaria Control Program. (2019). *Kenya Malaria Strategy 2019–2023*.

²⁴ The Global Fund to Fight AIDS, Tuberculosis and Malaria. (2022). *Mid-term Assessment: Kenya*, p. 16.

²⁵ Op cit at 17

access to services for MSM and TG, in addition to increasing threats to their safety and security.

The negative impacts of the legal and policy environment on progress to reduce human rights barriers are addressed throughout the findings of the assessment.

2.6 COVID-19

As noted in the MTA, which was conducted during COVID, the first case of COVID-19 was detected on March 13, 2020, and resulted in the immediate closure of schools and non-essential businesses and the prohibition of large gatherings, followed by a ban on international flights²⁶. Among other measures that the Kenyan government imposed to curb COVID-19 transmission were nightly curfews, mandatory quarantines, mandatory face masks in public spaces, shift work among government employees and recommendations to work from home for private sector and other employees, and hygiene campaigns²⁷. Some health care facilities that were used to deliver essential services were designated as COVID-19 isolation facilities, including treatment sites and storage facilities, and pandemic control measures also led to disruptions in service delivery, including for sexual and reproductive health services and activities for mass long-lasting insecticidal nets and TB case identification and notifications²⁸. As a result of COVID-19 measures, people living with or vulnerable to HIV, TB and malaria faced disruptions to services and supports and the stigma associated with COVID-19 was reported to have impeded uptake of health services, as people feared a COVID-19 diagnosis.

The enforcement of lockdown measures in Kenya also led to a documented increase in cases of sexual and gender-based violence against women and girls and triggered arbitrary arrests, beatings, torture, and extrajudicial killings by government forces, as Kenyan authorities were reported to have used violence to enforce curfews and lockdowns²⁹. Kenyan authorities forcibly quarantined thousands of people in facilities that further compromised their safety and health³⁰. In addition to increased risks of household and gender-based violence coupled with severe limitations in access to shelters for survivors due to the lockdown, studies highlighted the disproportionate impacts shouldered by women in Kenya during the pandemic, such as greater food insecurity and forgoing necessary health care, including for malaria treatment and family planning³¹.

²⁶ Kabale, N. (2020, March 24). *Coronavirus: Kenya takes BOLD steps after cases rise to three*. Nation.

<https://nation.africa/kenya/news/coronavirus-kenya-takes-bold-steps-after-cases-rise-to-three-278692?view=htmlamp>.

²⁷ Pinchoff, J. et al (2021) *Gendered economic, social and health effects of the COVID-19 pandemic and mitigation policies in Kenya: evidence from a prospective cohort survey in Nairobi informal settlements*. BMJ Open 11: e042749. <https://bmjopen.bmj.com/content/11/3/e042749>.

²⁸ Barasa, E. et al (2021, July 26). *Indirect health effects of the COVID-19 pandemic in Kenya: a mixed methods assessment*. BMC Health Services Research 21: 740. <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-021-06726-4>.

²⁹ Nnoko-Mewanu, J. and Muthiani, L. (2021, September 21). *"I Had Nowhere to Go": Violence Against Women and Girls During the Covid-19 Pandemic in Kenya*. Human Rights Watch. <https://www.hrw.org/news/2021/09/21/witness-sexual-violence-during-kenyas-covid-19-lockdown>.

³⁰ Segun, M. (2021, January 18). *Human rights abuses escalate in Africa during the pandemic*. Human Rights Watch. <https://www.hrw.org/news/2021/01/18/human-rights-abuses-escalate-africa-during-pandemic>.

³¹ Barasa, E. et al (2021, July 26). *Indirect health effects of the COVID-19 pandemic in Kenya: a mixed methods assessment*. BMC Health Services Research 21: 740 and Pinchoff, J. et al (2021) *Gendered economic, social and health effects of the COVID-19 pandemic and mitigation policies in Kenya: evidence from a prospective cohort survey in Nairobi informal settlements*. BMJ Open 11: e042749.

The Ministry of Health and counties adapted by using virtual platforms, extending drug collection schedules, implementing measures to allow patients already on treatment to continue collecting their drugs, and arranging for health care workers to deliver medicines to people's homes (and exempting some workers from movement restrictions to deliver essential services to households in need)³². The National AIDS and STI Control Program (NASCOP), in partnership with county governments, implementing partners and donors, also worked to ensure the continuity of key population service delivery during the pandemic, and issued technical guidance on issues ranging from setting up virtual coordination platforms to capacity building of service providers on HIV in the context of COVID-19. Program implementers, including community-led organizations, also described pivoting to communication with clients via social messaging groups and to virtual trainings and meetings, with some also providing recipients with technology to engage in this way.

2.7 Investments

The Global Fund currently invests in six grants addressing HIV, tuberculosis (TB) and malaria in Kenya, with total funding of up to US\$441 million allocated for 2021-2024. Two HIV grants were allocated funding for 2021-2024 of up to a combined total of US\$264 million to support interventions that aim to reduce new HIV infections by 75%, AIDS-related mortality by 50%, HIV-related stigma and discrimination by 25% and significantly increase domestic financing of Kenya's HIV response.

Two TB grants were allocated funding of up to a combined total of US\$96 million for 2021-2024. The investments work together to deliver interventions aimed at ensuring provision of quality care and prevention services for all people in Kenya with TB.

Funding of up to a combined total of US\$81 million was allocated for two malaria programs for 2021-2024. The funding supports Kenya in its mission to reduce malaria incidence and deaths by at least 75% of 2016 levels through a range of high-impact prevention, diagnosis and treatment interventions³³.

The 2021-2024 HIV/TB grant included a total amount of \$ 7.9 million under the human rights and gender module that was budgeted for addressing human rights and gender-related barriers to HIV, TB and malaria services within the Global Fund grant allocation and through Matching Funds.

In addition, USD 3.3 million was allocated to community systems strengthening (CSS) interventions, a number of which included components to address human rights-related barriers in the HIV, TB and malaria contexts. Stigma and discrimination and violence reduction interventions were also integrated into HIV prevention programming and received an amount of approximately USD 2 million.

A summary of the interventions included in this amount is shown in below along with an indication of the division of funds between the three Principal Recipients (PRs): National Treasury, Kenya Red Cross Society (KRCS) and AMREF.

³² Barasa, E. et al (2021, July 26). *Indirect health effects of the COVID-19 pandemic in Kenya: a mixed methods assessment*. BMC Health Services Research 21: 740.

³³ <https://data.theglobalfund.org/location/KEN/overview>

Summary of allocations by program area

Removing Barriers Program Area	National Treasury	KRCS	AMREF	TOTAL	%
Eliminate stigma and discrimination in all settings	854,478	2,826,567	0	3,681,045	46
Improve legal literacy ("Know Your Rights")	0	1,342,637	0	1,342,637	17
Ensure non-discriminatory provision of health care	229,424	27,660	0	257,084	3
Improve access to justice	93,933	707,208	0	801,141	10
Ensure rights-based law enforcement practices	91,959	333,186	0	425,145	6
Monitoring and reforming laws, regulations and policies relating to HIV and HIV/TB	169,892	698,799	0	868,691	11
Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity	160,592	393,650	0	554,242	7
Total	1,600,278	6,329,707	0	7,929,985	100
CSS Interventions					
Community-led monitoring (malaria)	0	0	201,211	201,211	5.6
Community-led advocacy and research (TB)	0	0	1,642,235	1,642,235	50
Social mobilization, community linkages and coordination (TB)	0	0	1,448,855	1,448,855	44
Institutional capacity building, planning and leadership development (TB)	0	0	12,130	12,130	0.4
Total			3,304,431	3,304,431	100

Of the funds for programs to reduce barriers and for CSS, KRSS and AMREF were allocated 86% (USD 9,634,138) of the total to support non-governmental and civil society partners. The remaining proportion was allocated under the National Treasury to support public sector efforts to reduce barriers. Program areas for stigma and discrimination reduction, legal literacy, monitoring and reforming laws and policies and access to justice received the most support across all PRs.

2.8 Implementation Arrangements

The implementation arrangements for programs to reduce barriers are shown below:

Implementation arrangements for programs to reduce barriers

Principal Recipients					
National Treasury	KRCS			AMREF	
Sub- recipients					
2 SRs	62 SRs			30 SRs	
NASCOP NSDCC	IRDO HIVA HFG Q-Initiative HWWK NEPHAK AMKENI HOYMAS NIAK RCT BHESP Hapa Kenya ISHTAR MAAYGO MIK SAPTA CMMB FASI ICWK MEWA Mzazi Foundation JIVIS NOPE	OGRA TWC AAF ADEO ADS Nyanza ADS Pwani AICHM APESE ERE APTDC C2R CHAO CONPHAK CREADIS Daraja DAUWOYE DEK FHK GEM GLOBCOM Hope Network KANCO KHAPPS	KICE MEI MOGROUP ONYX OPAHA Wajir Northstar Alliance SCPLNSG SIMAHO TOP WICODEP UCAHA WEFKO WVK KYDESA PEMA	Ananda Marga Universal Relief Team (AMURT) Blue Cross Nyatike Community Development Programme Brothers of St. Joseph Catholic Diocese of Muranga (CDM) Catholic Medical Mission Board (CMMB) Community Asset Building and Development Action (CABDA) Community Health Africa Trust (CHAT) Council of Imams and	Kibera Community Self Help Programmes- Kenya (KICOSHEP) Kipini International Community Konnnect Youth Consortium (KYC) Malteser International National Empowerment Network of People Living with HIV & AIDS in Kenya (NEPHAK) Neighbours in Action-Kenya (NIAK) Our Lady of Perpetual Support for People Living with AIDS and Orphans Outreach Pokot Rural Development

				Teachers of Kenya (CIPK) Daraja Mbili Vision Volunteers Youth Group Eagle Neema Self Help Group Hope World Wide Kenya (HWWK) Impact Research and Development (IRDO) KANCO Kenya Conference of Catholic Bishops (KCCB)	Project Self Help Group (PRDP) Respiratory Society of Kenya (ReSOK) Sisters Maternity Home (SIMAHO) SWOP Kenya Talaku Community Based Organization World Relief International World Vision Kenya (WVK) Youths Fighting HIV and AIDS in Kenya (YOFAK)
--	--	--	--	--	--

The program areas addressed by each implementer are summarized below:

Implementers and program areas

Program Areas	KRCS	AMREF	National Treasury
HRG			
Stigma and Discrimination Reduction	X		X
Ensure non-discriminatory provision of health care	X		X
Legal Literacy ("know your rights")	X		
Improve access to justice	X		X
Ensuring rights-based law enforcement practices	X		X
Monitoring, Reviewing Law & Policy	X		X

Gender Inequality & GBV	X		X
CSS			
Community-led monitoring (malaria)			X
Community-led advocacy and research (TB)			X
Social mobilization, community linkages and coordination (TB)			X
Institutional capacity building, planning and leadership development (TB)			X

3. Towards Comprehensiveness: Achievements and Gaps in Scope, Scale and Quality

3.1 Progress to remove barriers to HIV services

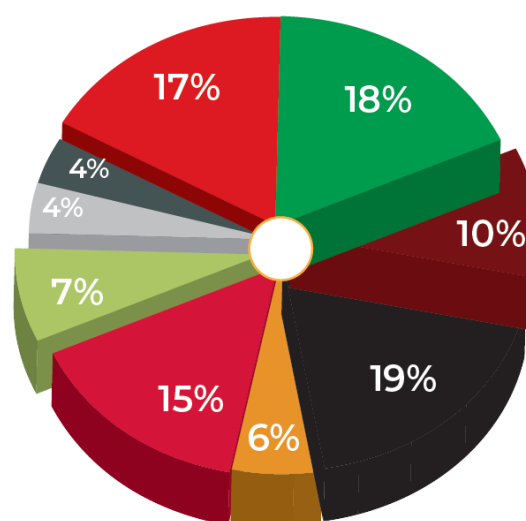
Over the 2022-2023 assessment period, Kenya continued to make progress to reduce human rights-related barriers to HIV services. For most program areas, there was a significant scale-up of activities (an increase in outputs), largely as a result of the increased investment under the current GF grant, but also due to increased contributions from other funders and partners. A number of interventions undergoing scale-up were continuations from the previous grant cycle (2019-2021).

A 2022 CSOs mapping exercise undertaken by KeNAAM, tasked by AMREF with support from the GF to generate a database of civil society organizations involved in malaria, HIV, TB, and other related health programs in all 47 counties showed that of the CSOs working on HIV, 19% of these were working on protecting the rights of people to live a life free from violence, discrimination and discrimination, 17% were working to promote leadership, communication and advocacy, and 15% were working to leverage community led programs for an effective response³⁴.

³⁴ MAPPING OF KENYA CIVIL SOCIETY ORGANIZATIONS WORKING IN SECTOR REPORT MALARIA, HIV & TB, Kenaam 2022

HIV Programme Thematic Areas

- **Thematic Area 1:** Universal access to comprehensive, quality and integrated IV and STIs prevention service.
- **Thematic Area 2:** Revitalise shared fast-track commitment towards achieving of treatment targets
- **Thematic Area 3:** Protect the rights of people to live a life free of violence, stigma and discrimination.
- **Thematic Area 4:** Invest in resilient systems for HIV and other health outcomes
- **Thematic Area 5:** Leverage on communities led programmes for an effective response.
- **Thematic Area 6:** Integrate HIV in humanitarian and emergency responses
- **Thematic Area 7:** Promote translation of strategic information
- **Thematic Area 8:** Invest in long-term HIV financing model
- **Thematic Area 9:** Promote leadership, communication and advocacy



Progress was less certain, however, with regard to whether these scaled-up interventions had reduced or removed human rights barriers (increase in outcomes), or whether the reduction of barriers improved access and uptake of services (emerging evidence of impacts). These changes are described in the detailed findings by program area set out below.³⁵

(a) Eliminate stigma and discrimination in all settings

HIV program area	Score ³⁶		
	Baseline (2021)	Mid-Term (2022)	Progress (2023)
Eliminate stigma and discrimination in all settings	2.0	3.5	4.0

The elimination of stigma and discrimination is a Global Fund program essential³⁷ and thus should be at the core of the national HIV response in Kenya. Global stakeholders have prioritized six settings for the elimination of HIV-related stigma and discrimination, including amongst individuals, households and communities; within healthcare, education, workplace, justice and legal systems; and in emergency and

³⁵ Starting with the GC7 funding cycle, the Global Fund introduced program essentials, defined as "key evidence-based interventions and approaches identified by partners as being necessary for achieving the global goals of ending the three diseases as epidemics by 2030, and as such should be at the core of all national disease programs." A number of program areas to reduce or remove human rights-related barriers are considered to be program essentials. Where relevant, this is indicated in the findings.

³⁶ See **Annex 1** for the interpretation of the scores.

³⁷ Program Essentials are key evidence-based interventions and approaches identified by partners as being necessary for achieving the global goals of ending the three diseases as epidemics by 2030, and as such should be at the core of all national disease programs.

humanitarian settings.³⁸ Efforts to eliminate HIV-related stigma and discrimination in Kenya address all settings but with varying degrees of focus and effectiveness. Kenya's commitment to eliminating stigma and discrimination is reflected in its participation in the Global Partnership for Action to Eliminate All Forms of HIV-Related Stigma and Discrimination (the Global Partnership), with a chosen focus on the education, employment and health sectors. Interventions supported by the BDB Initiative contribute to Kenya's overall goals and commitments as part of the Partnership.

HIV-related stigma and discrimination in many forms and several settings have been identified for several years in national HIV strategies in Kenya as key barriers to seeking, using and adhering to HIV services. The reduction of HIV-related stigma and discrimination is a key overarching principle of the current national HIV strategy, the Second Kenya AIDS Strategic Framework | 2020/21-2024/25 (KASFII) which recognises that Progress in elimination of HIV related stigma and discrimination is off track and that there is a need to address policy and legal barriers that impact negatively on access to HIV services³⁹. One of the objectives of KASFII is to reduce HIV related stigma and discrimination to less than 25%⁴⁰.

Reduction of HIV-related stigma and discrimination is also a central element of the *Strategic Plan: Comprehensive response to human rights and gender-related barriers to HIV, TB and malaria services in Kenya (2021-2024)*.⁴¹

Though efforts to address HIV-related stigma and discrimination have been pursued in Kenya for years, stigma and discrimination remain pervasive, 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 areas⁴².

The 2014 National HIV and AIDS Stigma Index Report⁴³ showed that HIV-related stigma and discrimination in Kenya was at 45%, with marked regional variations. Although awareness of HIV and AIDS is comparatively high in Kenya, people living with HIV in Kenya still experience stigma and discrimination. Location-specific stigma and discrimination have been widely reported in health care settings⁴⁴. In 2015 18.1% of respondents in a national study on human rights violations against people living with HIV reported experiencing human rights violations within health care settings (third only to discrimination within the family (79%) and in workplace settings (34%)⁴⁵. Stigma and discrimination are reported to be higher in rural areas than urban areas, and particularly in the ASAL region⁴⁶.

³⁸ See UNAIDS. 2020. *Evidence for eliminating HIV-related stigma and discrimination*. Available: https://www.unaids.org/sites/default/files/media_asset/eliminating-discrimination-guidance_en.pdf

³⁹ Second Kenya AIDS Strategic Framework | 2020/21-2024/25 (KASFII) at p 11

⁴⁰ Op cit at 4

⁴¹ *Strategic Plan: Comprehensive response to human rights and gender-related barriers to HIV, TB and malaria services in Kenya (2021-2024)*.

⁴² MTA p24

⁴³ National HIV and AIDS Stigma Index Report, NACC, 2014:1

⁴⁴ ibid

⁴⁵ ibid

⁴⁶ Baseline Assessment op cit: 41

Internalized stigma and intersectional stigma due to HIV status and membership of a key population serves as a deterrent to attending health facilities for fear of being reported to the police⁴⁷. Stigma was blamed for late presentation of MSM living with HIV resulting to disproportionately higher HIV related morbidity and mortality⁴⁸.

The most recent People Living With HIV Stigma Index report for Kenya (2021) shows that despite a significant decrease among respondents of experiences of HIV-related stigma and discrimination from 45% in 2014 to 23% in 2020⁴⁹, HIV-related stigma and discrimination remain a major challenge in the response to HIV due to persistent negative attitudes towards people living with, at risk of and affected by HIV despite decades of public information campaigns and other awareness-raising efforts. According to the 2021 People Living With HIV Stigma Index report, over the last 12 months, the most reported form of stigma or discrimination experienced by PLHIV due to their status included: being subjected to discriminatory remarks or gossip by either family (20.14%) or non-family members (24.66%) and verbal harassment (20.14%). Respondents reported various forms of stigma for HIV-related care in the hands of health facility staff including gossip/talking badly of (14% of men and 13% of women); disclosure without consent (12% for both men and women); and avoidance (10% for men vs. 9% for women).

In particular, the 2021 HIV Stigma Index survey revealed people living with HIV who had been denied employment or a promotion due to their HIV status, reflecting a significant portion of the complaints that the HIV and AIDS Tribunal receives⁵⁰.

A comparison between the levels of internalized stigma among both female and male respondents living with HIV reported in the 2014 and 2021 HIV Stigma Index reports reveals that internalized stigma remains a substantial problem. The 2014 HIV Stigma Index stated that blatant discrimination against PLHIV was reported to affect self-perception with a high proportion (45.9%) of PLHIV respondents reporting that they perceived HIV infection to be a punishment from God and (61%) for bad behavior. In addition, HIV stigma led to low self-esteem and depression among PLHIV with three out of four PLHIV interviewed reporting they had contemplated suicide at some point in their lives. Nearly 90% of PLHIV interviewed indicated that they suffered so much stress as a result of stigma⁵¹. The 2021 HIV Stigma Index revealed that seventy-one% of men and 69% of women reported that it was difficult to tell people about their HIV status. Sixty-two% of men and 64% of women indicated that they hide their HIV status from others. Almost a third of both men and women (range 31-34%) felt worthless or guilty because of their HIV status. Men reported higher levels of shame than women (31.48% vs. 27.34%). About one-fifth of respondents reported that being HIV positive made them feel dirty⁵².

⁴⁷ KELIN. (2018). Tuberculosis: Data Assessment in Key, Vulnerable, And Underserved Populations in Kenya.

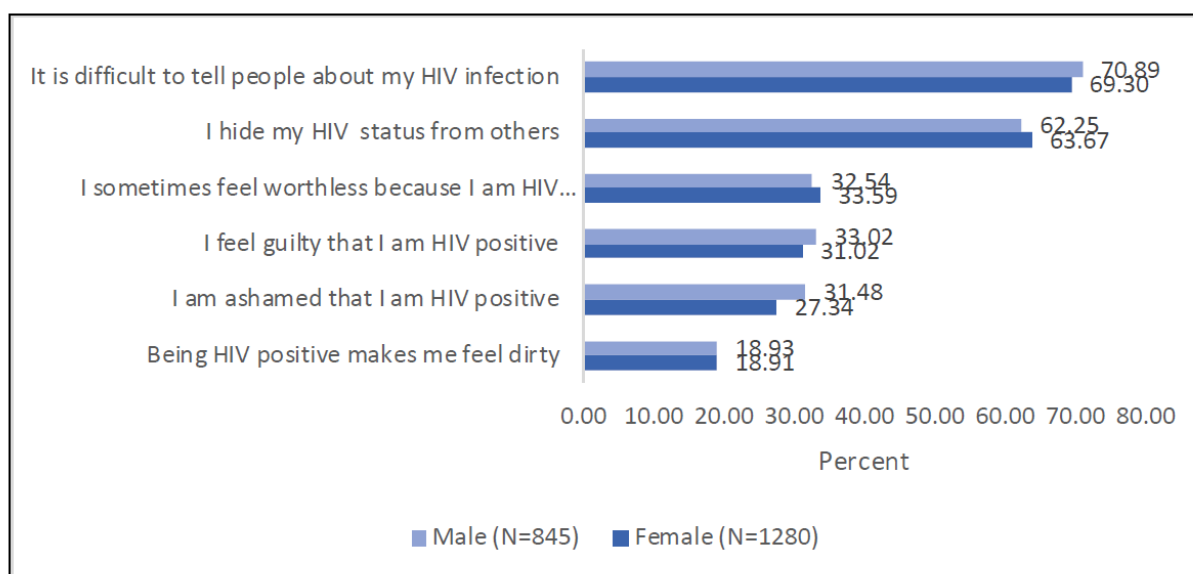
⁴⁸ National HIV and AIDS Stigma Index Report, NACC, 2014:17

⁴⁹ Whilst the methodologies employed in the 2014 and 2021 stigma surveys were different, which makes actual comparison of levels of discrimination difficult, it is clear that there has been a decrease in HIV-related stigma and discrimination since 2014.

⁵⁰ Eba, P. (2016, June). *The HIV and AIDS Tribunal of Kenya: An Effective Mechanism for the Enforcement of HIV-related Human Rights?* Health Hum Rights 18(1): 169–180.

⁵¹ The National HIV and AIDS Stigma and Discrimination Index 2014 • Summary Report p18 <https://www.kelinkkenya.org/wp-content/uploads/2018/12/HIV-stigma-index.pdf>

⁵² NEPHAK: The PLHIV Stigma Index: Kenya Country Assessment 2021, p48, 49



Source: NEPHAK: The PLHIV Stigma Index: Kenya Country Assessment 2021

As noted by the Kenya Mid-term Assessment: Breaking Down Barriers Initiative (MTA) published in March 2022, in order to address HIV-related stigma and discrimination NACC (now NSDCC) mandated that every Ministry develop and implement a workplace policy on HIV prohibiting stigma and discrimination and employ a program officer to coordinate a workplace program to sensitize employers and employees on the effects of such stigma and discrimination — targeting specific counties and private and public sector workplaces.

Progress since the MTA

The 2021 HIV Stigma Index shows a marked decrease in HIV-related stigma and discrimination since 2014, which is a remarkable achievement. It is however evident that stigma and discrimination remain a challenge for PLHIV and KPs in the community, employment, health care and education settings. In addition, internalized stigma remains at relatively high levels.

In order to address the latter, the Kenya Red Cross Society (KRCS), a principal recipient under GC6, organizes support groups for PLHIV. The objectives of the support groups are to reach out to PLHIV, to share health information on HIV services, ART, adherence to treatment and nutrition education and to sensitize project beneficiaries on adherence and disclosure. The support groups also serve as fora for sensitization on antiretroviral therapy literacy, adherence to ART drugs for all participants, risks associated with drug/alcohol and substance abuse amongst PLHIV, stigma, discrimination, nutrition and embracing disclosure of their status to treatment supporters. In addition, KRCS supports structured dialogue sessions with AGYW living with HIV and women living with HIV which are designed to support participants to accept HIV testing and counselling, to prevent mother-to-child HIV transmission (PMTCT) and to assist them to overcome real or perceived HIV-related stigma and

discrimination, as well as other barriers that affect their decision-making concerning HIV testing, prevention and use of PMTCT services⁵³.

The National Syndemic Diseases Control Council (NSDCC) (previously NACC), a sub-recipient under The National Treasury, has focused on addressing stigma and discrimination in the employment and education sectors in line with the MTA recommendations as well as stigma & discrimination among key and vulnerable populations, gender discrimination and gender-based violence.

NSDCC has engaged in sensitization sessions and advocacy with employers in the public, private and informal employment sectors on the need to make provision for non-discrimination on the basis of both HIV and TB in all workplace policies and to ensure adherence to these policies. A particular focus has been placed on the informal employment sector, which traditionally has received less attention than the public and private employment sectors on this issue. NSDCC has also strengthened mechanisms for the prevention, reporting, and referral of HIV/TB & Malaria related human rights violations, including GBV, stigma and discrimination at the county level and has also worked to address HIV-related stigma and discrimination in the education sector.

Progress to address the recommendations in the MTA report is largely on track as illustrated in the table below:

MTA Recommendations	Implementation status		Comments
	YES	NO	
a) Broadly disseminate results of the HIV Stigma Index, targeting relevant government ministries	X		
b) Based on the findings of the 2020 HIV Stigma Index, develop a 3-year action plan that includes an advocacy and communications strategy		X	<ul style="list-style-type: none"> Instead of developing a stand alone action plan, stigma and discrimination reduction activities have been incorporated into the three-year <i>Strategic Plan: Comprehensive response to human rights and gender-related barriers to HIV, TB and Malaria services in Kenya (2021-2024)</i>.
c) Task NACC (now NSDCC) with supporting workplaces to develop and implement reporting mechanisms when discrimination occurs.	X		NSDCC has: <ul style="list-style-type: none"> Revised the Public Sector workplace policy to ensure non-discrimination on the basis of both HIV and TB. Conducted three meetings with the private and informal sector representatives on HIV and TB related stigma and discrimination in

⁵³ KRCS LER progress report January to June 2022.

			the workplace, of which two were virtual and one was face to face. The latter reached 37 participants drawn from the Micro and Small Enterprises Authority, targeting the informal sectors in Nairobi County. The two virtual meetings reached 65 and 102 participants respectively drawn from the Central Organization of Trade Unions (COTU) membership and the informal sector.
d) Establish an informal economy steering committee within the human rights and gender technical working group on HIV, TB and malaria to advise associations within the informal economy about stigma and discrimination in the workplace.	X		<ul style="list-style-type: none"> • See above
e) Scale up sensitization of public and private sector employers and employees on workplace policies prohibiting stigma and discrimination and develop and implement available recourse for violations.	X		<ul style="list-style-type: none"> • See above
f) Publish media guidelines and scale up engagement with and sensitization of journalists on human rights and gender related barriers related to HIV, TB and malaria.	X		<ul style="list-style-type: none"> • In addition to media guidelines and engagement that has already taken place, provision has been made in the GC7 Funding Request for the development and dissemination of an additional guide for media practitioners on rights and evidence-based reporting on HIV, TB, KP and human rights and utilize guide for training of media in response to the sensationalist reporting on KPs that has been seen in the wake of the introduction of the Family Protection Bill.
g) Scale up county level sensitization of county leaders on stigma and discrimination	X		NSDCC has: <ul style="list-style-type: none"> • Established and supported the operation of Multisectoral County & Constituency Human Rights and Gender Coordinating Committees as well as Human Rights and Gender County Technical Working Groups

			<p>(TWGs) in the 15 Priority Counties, which meet quarterly to strengthen the prevention, reporting, and referral of HIV/TB & Malaria related human rights violations, including GBV, stigma and discrimination.</p> <ul style="list-style-type: none"> • Expanded the operation of the Human Rights and Gender County TWGs to all 47 counties with the support of additional funds from the Government of Kenya. • Hosted Multisectoral sensitization and engagement fora with key national, county & community stakeholders and representatives of people living with HIV, people with TB and key and vulnerable populations to seek solutions to human rights barriers to access to TB and HIV services, and to address stigma & discrimination among key and vulnerable populations, gender discrimination and GBV in 30 counties. 1956 participants were reached comprising representatives from the Ministry of Interior, National Government Officials (Chiefs), Gender Desk Police officers, the Ministry of Social Protection, County Departments of Health, Children's services, Gender, and Youth, Directorate of Public Prosecutions, the Faith sector, and the CSOs.
h) Sensitize education authorities, teachers at primary and secondary schools, and educators at tertiary institutions on HIV, TB, and gender related discrimination in learning	X		<ul style="list-style-type: none"> • NSDCC has scaled up the national sensitization of BEACON and KENEPOTE teachers, in partnership with the MOE and TSC and State Department of TVET, on HIV, TB, and gender-related stigma and discrimination in learning institutions in 5 counties (Wajir, Garissa, Kirinyaga, Mombasa and Kakamega) with high and medium stigma to ensure non-discrimination in the education sector. In this process, 165 teachers from KENEPOTE and Beacon of Hope in 5 counties were reached with information on HIV, TB & GBV & Children's Rights, supporting learners living with HIV & pregnant

			AGYW, and age-appropriate sexuality education.
<ul style="list-style-type: none"> Review and disseminate national faith sector action plan to include HIV and TB related stigma and discrimination messaging and continue sensitization of faith and community leaders, in partnership with people living with HIV and key population organizations. 	X		<ul style="list-style-type: none"> NSDCC has revised the National Faith Sector Action Plan to include HIV & TB-related stigma and discrimination reduction congregational messages.

SW, MSM, TG and PWUD still face high levels of S&D in health care and community settings and at hands of law enforcement due to their identity and also due to their HIV status, with varying levels and forms for each group:

- Sex Workers reported high levels of stigma and discrimination including emotional violence (30.07%), physical violence (24.94%), blackmail (18.49%), and discriminatory remarks/gossip (23.39%).
- About 20% of Transgender community reported experiencing physical violence.
- About 1 in 5 (17.83%) of Sex Workers reported having avoided seeking healthcare services due to fear of being identified as Sex Workers within the last 12 months of the study and beyond.
- About 1 in 5 (20%) Transgender respondents reported having avoided seeking healthcare services to avoid disclosing their gender identity.
- About 1 in 5 (17.75%) of Persons Who Use or Inject Drugs (PWUD) reported being afraid of seeking health services or avoided seeking health services in the past 12 months due to fear of someone discovering that they use (had used) or inject drugs⁵⁴.

The Mid-Term Assessment found that punitive laws that discriminate against key populations and criminalize HIV exposure and transmission, non-reporting of a person infected with TB and TB exposure, living on the earnings of and soliciting sex work, the sale of sterile injection equipment, and same sex sexual relationships fuel stigma, discrimination and violence against key populations, undermine trust in health services, and create barriers to accessing health services. Police have been reported to engage in abusive practices against key populations, including harassment, extortion, arbitrary arrest, and physical and sexual violence, and have also failed to adequately provide protection in times of need⁵⁵. Unfortunately, the situation remains the same at the time of this progress assessment and has been exacerbated by the recent tabling of the Family Protection Bill that further criminalizes same sex sexual

⁵⁴ NEPHAK: PLHIV Stigma Index 2.0 Kenya Country Assessment 2021 at <https://nephak.or.ke/wp-content/uploads/2021/09/Kenya-PLHIV-Stigma-Index-2.0-Report-NEPHAK.pdf>

⁵⁵ Op cit at 17

relationships that has and will continue to create severe barriers to access to services for MSM and TG, in addition to increasing threats to their safety and security.

Stigma and discrimination against sex workers, MSM and people who inject drugs, exacerbated by punitive laws referred to above have resulted in some counties to resistance on the part of local leaders to the implementation of HIV prevention programming for members of these populations. In order to address this, KRCS and NASCOP conducted advocacy visits to the counties of Samburu and Marsabit with a view to sensitizing the respective CHMT, National government Administrative Officers (NGAO), Judiciary, village elders and local women and religious leaders on key population HIV programs. Participants were briefed on the right to health and the importance of HIV programming for key populations for general public health. Following these meetings, the county leaderships in both countries committed their support for the key population HIV programs (for MSM, FSW and PWID in Marsabit and for FSW in Samburu).

Gaps and challenges

In other regions however stigma and discrimination against MSM, MSW and TG have continued to escalate as a result of the tabling of the Family Protection Bill. Mombasa has, for example, seen numerous anti-LGBTI demonstrations since the tabling of the Bill which have received visible support from some prominent politicians. As a result there has been an increase in attacks and profiling of members of the LGBTI community as well as in incidences of GBV and evictions from their homes. In addition the MSM /TG drop in center and clinic operated by a KRCS SR in Mombasa as well as other similar drop in centers and clinics were closed for two months in March 2023 due to ongoing anti-LGBTI demonstrations and safety and security concerns. High levels of stigma and discrimination against MSM, TG and MSW has also resulted in institutions such as the police who had previously been allies being hesitant to come to the assistance of the LGBTI community⁵⁶. Similar problems have been reported by a KRCS SR operating in Kilifi County, where anti-LGBTQ demonstrations have made it impossible to program for KPs in Lamu and Kilifi. The Lamu drop-in centre was closed on the directive from county leadership regarding KP programming. Similar to the situation in Mombasa this SR lost allies in KP programming (both due to change in county leadership and ongoing protests at the coast). They previously enjoyed a good relationship with the county government and other key stakeholders e.g. religious leaders and police. The drop-in center in Kilifi was also closed temporarily during the protests and some peer educators and outreach workers resigned out for fear for their safety. Several were evicted from their homes. The executive director of the SR also has to temporarily leave Kilifi for two months during the protests and was outed to his family by religious clerics. There was also an increase in GBV cases reported against members of the LGBTI community⁵⁷. Stigma and discrimination against MSM in health facilities has also increased. A recent message written on the wall of the Malindi Hospital read *“Hatutaki Mashoga Malindi”* (*“We do not want MSM in Malindi”*)⁵⁸.

Progress on addressing stigma and discrimination in health care settings has been slow in general. This is dealt with in more detail in the section on ensuring non-

⁵⁶ KI Interview HAPA Kenya

⁵⁷ 178 cases were reported since protests started in March 2023.

⁵⁸ KI Interview Amkeni

discriminatory health care below. Similarly progress on addressing stigma and discrimination in humanitarian settings has been slow.

As is evident from the above, there have been increasing efforts to integrate TB into HIV-related stigma and discrimination reduction programming. There are however mixed feelings about the effectiveness of this integration and concerns have been expressed by key informants interviewed for the purposes of this assessment that the association between TB and HIV increases stigma against PLTB and that there is the additional risk that TB-related stigma is given less attention than HIV-related stigma when these programs are integrated⁵⁹.

Recommendations

While the majority of the recommendations made in the MTA have been implemented, and stigma and discrimination reduction programming has been scaled up, focus should be placed on ensuring that stigma and discrimination data are regularly updated to inform future scaled up programming and on addressing the gaps identified by this assessment, including further scaling up of programming to address stigma and discrimination in the employment, health and education sectors, addressing sensationalist reporting on key populations in the media and the lack of stigma and discrimination reduction programming in the humanitarian sector. This assessment thus recommends the following:

- Conduct a Stigma Index 3.0 Survey to inform future stigma and discrimination reduction programming and consider expanding the scope of the survey or conducting an additional survey to capture the attitudes of the general population towards people living with HIV.
- Scale up sensitization and institutional support to teachers and county education officers in all counties to address HIV and TB-related stigma and discrimination and GBV.
- Scale up programming to address internalized stigma.
- Scale up programming to address HIV-related stigma and discrimination in family settings.
- Ensure the meaningful participation of PLHIV and KP in the design and implementation of stigma and discrimination reduction programs.
- Scale up the implementation and enforcement of workplace policies and other measures to reduce HIV, TB and KP-related stigma and discrimination in public, private and informal sectors, with a particular focus on the informal sector.
- Develop and disseminate a guide for media practitioners on ethical, rights and evidence-based reporting on HIV, TB, KP and human rights and utilize the guide for training of media. (particularly in view of the sensationalized reporting on the Family Protection Bill and the impact of this reporting on KP-related stigma and discrimination as well as on their safety and security).
- Scale up support to MSM and TG led organizations to address increased levels of stigma and discrimination by targeting religious leaders and landlords following the tabling of the Family Protection Bill and ensuing public anti-LGBTI demonstrations and violence.

⁵⁹ For example KI interview with NTLP staff 29 May 2023

- Undertake research on how stigma and discrimination manifests in humanitarian settings and use the resulting information to ensure that the existing HIV & TB in humanitarian settings coordination framework is supported to co-ordinate programming to address stigma and discrimination and other human rights violations in humanitarian settings.
- Support community-based and -led organizations to address HIV, TB and KP-related stigma and discrimination and other human rights violations against refugees and IDPs. Scale up multi-sectoral sensitization and engagement fora for key national, county, community and religious leaders, PLHIV and KPs to address human rights and gender-related barriers to access HIV and TB services in “high stigma” counties.

(b) Ensuring non-discriminatory provision of health care

HIV program area	Score		
	Baseline (2021)	Mid-Term (2022)	Progress (2023)
Ensure non-discriminatory provision of health care	2.0	2.5	2.7

Health care settings are one of the priority settings for the elimination of all forms of stigma and discrimination and have been identified as a Global Fund “program essential” for the countries where it invests. Health care provision should occur in settings that are welcoming, accepting, caring and supportive for all, including those at risk of and affected by HIV, in all their diversity. Health services wherever they are offered should be free from any form of stigma or discrimination based on health condition, ability, socio-economic status or any other individual or group characteristic. In Kenya, efforts continue to be made, through NASCOP and the NSDCC, to achieve and maintain non-discriminatory provision of HIV, TB and other related health care services.

As noted in the MTA report⁶⁰ while most health care providers report an understanding of and respect for patients’ rights (including rights in the *Kenya National Patients’ Rights Charter*) and many report having received training on HIV and human rights, stigma and discrimination against people living with HIV and key populations persist in health care institutions, as documented in the second HIV Stigma Index survey, the baseline assessment, and other research. These manifest as verbal abuse and non-consensual disclosure of HIV status by health care workers, lack of accessible and appropriate health services, and denial of health services. Respondents to the second HIV Stigma Index Survey reported various forms of stigma for HIV-related care in the hands of health facility staff including gossip/talking badly of (14% of men and 13% of women); disclosure without consent (12% for both men and women); and avoidance (10% for men vs. 9% for women)⁶¹. Delayed HIV testing and disruptions to HIV treatment were consequently attributed to concerns about confidentiality and stigma within health care settings.

⁶⁰ MTA Report 2022 p28-29

⁶¹ NEPHAK: PLHIV Stigma Index 2.0 Kenya Country Assessment 2021 at <https://nephak.or.ke/wp-content/uploads/2021/09/Kenya-PLHIV-Stigma-Index-2.0-Report-NEPHAK.pdf>

Key populations including sex workers, people who use drugs and transgender people reported avoiding seeking health care due to fear of being identified as a sex worker or a person who uses drugs — or for transgender people, to avoid disclosing their gender identity. This is evidenced by the data below from the second HIV Stigma Index Survey:

- About 1 in 5 (17.83%) of Sex Workers reported having avoided seeking healthcare services due to fear of being identified as Sex Workers within the last 12 months of the study and beyond.
 - About 1 in 5 (20%) Transgender respondents reported having avoided seeking healthcare services to avoid disclosing their gender identity.
- About 1 in 5 (17.75%) of Persons Who Use or Inject Drugs (PWUD) reported being afraid of seeking health services or avoided seeking health services in the past 12 months due to fear of someone discovering that they use (had used) or inject drugs⁶².

Progress to address the recommendations in the MTA report has been limited as illustrated in the table below:

MTA Recommendations	Implementation status		Comments
	YES	NO	
<ul style="list-style-type: none"> • Finalize and integrate the HIV, TB and human rights training module in the pre-service medical trainings for all health care workers and build capacity of health care training institution personnel to deliver the preservice human rights curriculum, including via collaboration with people living with HIV and key population organizations. 		X	<ul style="list-style-type: none"> • Despite being budgeted for in GC6, the module has not been finalized, nor has it been integrated into pre-service training for health care workers.
<ul style="list-style-type: none"> • Institutionalize regular, in-service refresher training for all health facility staff on HIV, TB, human rights, gender equality (including training related to gender-based violence and sexual and reproductive health) and medical ethics, including on the Kenya National Patients' Rights Charter. 	X		<ul style="list-style-type: none"> • NASCOP has conducted in-service training for health care workers. In the absence of a finalized training manual, it is not clear however what materials are being used to conduct this training.

⁶² ibid

<ul style="list-style-type: none"> Produce and implement standardized training curriculum for community health volunteers on HIV, TB, human rights, gender equality (including training related to gender-based violence and sexual and reproductive health and medical ethics and support ongoing training for community health volunteers. 		X	<ul style="list-style-type: none"> There is no evidence of a standardized training manual for community health volunteers having been produced.
<ul style="list-style-type: none"> Support implementation of a monitoring and evaluation system to document impact of human rights related training on health outcomes, disaggregated based on sex, gender identity and sexual orientation. 		X	<ul style="list-style-type: none"> There is currently no monitoring and evaluation system in place that provides for documenting the impact of training of HCW on health outcomes.
<ul style="list-style-type: none"> Support civil society and key population led organizations to continue and scale up community led monitoring of human rights violations, including violations perpetrated by health care workers towards people living with HIV, TB or malaria, and incorporate findings of such monitoring into training for health care workers and for advocacy purposes. 	X		<ul style="list-style-type: none"> KRCS is providing trainings for CHPs, PLHIV and TB Champions, Peer Educators, Paralegals, Expert Mothers, Mentor Mothers, Outreach Workers in 6 counties in the Lower Eastern Region on the use of the I Monitor+ ATM Kenya App, which is a Community Led Monitoring tool that permits the reporting of issues experienced by communities at health care facilities that require an action from CSOs and Government.

Progress and challenges

As noted by the MTA, a desk-based assessment undertaken by NASCOP in 2020 of health care worker knowledge of human rights, medical ethics, HIV, TB, privacy, and confidentiality revealed their minimal knowledge of human rights and the law and what actions constitute human rights violations, confirming previous research exposing underdeveloped awareness of patients' human rights among Kenyan health care workers, even where clinics or hospitals have written policies or standards of practice outlining these rights⁶³.

⁶³ MTA Report 2022 p28

To address this, NASCOP has carried out in-service training of health care workers on HIV, TB, law, human rights and ethics in the context of health care. Whilst under the GC5 grant there were a number of activities undertaken to ensure the provision of non-discriminatory HIV services, including the publication by NASCOP in 2018 of *Addressing HIV and Key Population Stigma and Discrimination: Health Workers' Training Guide for the provision of quality, stigma-free, HIV services for key populations in Kenya*, the dissemination of resources on human rights, law and human rights violations to health care workers in 10 “high stigma” counties, the training of health care workers on sex workers rights by key population-led organizations and the training of community health volunteers on HIV and human rights, efforts seem to have diminished under the current GC6 grant as reflected on below.

The MTA noted that NASCOP intended to integrate all human rights-related HIV and TB content into one module and integrate this into the pre-service curricula at all health care worker training institutions. Despite this activity having been budgeted for under GC6 it appears that the training manual has yet to be finalized and that funds allocated for the finalization of the manual and the integration of the module into pre-service training has been reprogrammed for in-service training of health care workers. In the absence of a finalized training manual, it is not clear what materials are being used to undertake the in-service training. The assessment team was unable to access data on the number of health care workers that have undergone in-service training.

As was the case in the MTA, key informants again highlighted the need to train more community health volunteers, who are ideally situated to provide information about HIV, TB and human rights and to provide support services and to finalize and integrate the module on HIV, TB and human rights into all health care worker pre-service training.

KRCS is providing trainings for CHPs, PLHIV and TB Champions, Peer Educators, Paralegals, Expert Mothers, Mentor Mothers, Outreach Workers in 6 counties in the Lower Eastern Region on the use of the I Monitor+ ATM Kenya App, which is a Community Led Monitoring tool that permits the reporting of issues experienced by communities at health care facilities that require an action from CSOs and Government. The I Monitor+ ATM Kenya App is a community-owned tool to monitor and respond to the needs in real-time. This tool leverages technology to enable monitoring, recording and reporting of the quality of services, as experienced by AYP and other key and vulnerable populations.⁶⁴

Recommendations

While in-service health care worker training on HIV, TB, human rights and medical ethics continues to be scaled up, this work is taking place at a limited pace, is still inadequate to meet needs, and is insufficiently monitored and evaluated. Pre-service training requires institutionalization to deal with loss of trained staff within facilities. The Assessment recommends the following:

- Finalize and integrate HIV and human rights training modules in the pre-service training for all health care workers and build capacity of health care training institution

⁶⁴ LER report Jan to June 2022

personnel to deliver the pre-service human rights curriculum, including via collaboration with people living with HIV and key population organizations.

- Institutionalize regular, in-service refresher training for all health facility staff on HIV, TB, human rights, gender equality (including training related to GBV and SRH) and medical ethics, including on the Kenya National Patients' Rights Charter.
- Produce and implement standardized training curriculum for community health volunteers on HIV, TB, human rights, gender equality (including training related to GBV and SRH and medical ethics and support ongoing training for community health volunteers.
- Support implementation of an M&E system to document not only the number of health care workers trained but also the impact of human rights related training on health outcomes, disaggregated based on sex, gender identity and sexual orientation.
- Support civil society and key population led organizations to continue and scale up community led monitoring of human rights violations, including violations perpetrated by health care workers towards people living with HIV, TB or malaria, and incorporate findings of such monitoring into training for health care workers and for advocacy purposes.

(c) Legal Literacy (“know your rights”)

HIV program area	Score		
	Baseline (2021)	Mid-Term (2022)	Progress (2023)
Legal literacy (“know your rights”)	1.0	2.5	3.6

As noted in the MTA, at baseline, several legal literacy programs were identified that were limited in scale and reach. Some larger peer education efforts were noted, but these did not include human rights or legal literacy content. At mid-term however, there was a wider array of legal literacy efforts, carried out across the country by organizations and entities such as KELIN, UNDP, networks of people living with HIV and key population-led organizations, often via peer educators, though limited legal literacy programming was identified for people who use drugs.

The MTA noted the following legal literacy programs:

- NASCOP oversees a unit that assesses knowledge gaps in peer education programming and produces training manuals and guidelines. The MTA found that over the past five years, NASCOP had published manuals for the leadership of community-based organizations to train their staff on human rights and support for survivors of violence, guidelines for specific key population peer educators, and a protocol for entities working with key populations to prevent and respond to violence against key populations. NASCOP training begins with peer education, after which peers are trained on advocacy skills and on violence prevention and response. At the time of the MTA (2021), NASCOP had trained 195 key population paralegals representing sex workers, men who have sex with men, and members of the LGBT community in

Training of Trainers workshops. KRCS-supported paralegals had also been trained on gender-based violence and participate in various platforms to educate community members on violations against people living with HIV and gender-based violence, in some instances targeting community leaders to address harmful cultural practices.

- KRCS and NACC had trained people living with HIV on human rights and recourse for rights violations — information that these peer educators are meant to further cascade to peers through support groups and community meetings. These trainings were often done in partnership with NEPHAK, the Kenya Key Population Consortium, and with youth networks such as Maisha Youth. Building on existing peer education work, in 2021, with support from the Global Fund, the KRCS produced two “Know Your Rights” manuals for peer educators targeting people living with HIV and adolescents and young people. Using these manuals, KRCS trained 240 Training of Trainers representing people living with HIV and adolescents and young people in 18 counties.
- Targeting young men, Boda Boda riders and fisher folk, NACC partnered with the Ministry of Transport, Department of Fisheries, Ministry of Interior and Coordination, the Boda Boda Association and Beach Management units in 2019 to train 210 Boda Boda riders in Homabay, Kwale and Kisumu counties and 140 fisherfolk in Kilifi and Migori counties as peer educators — facilitating their engagement with more than 8900 peers to discuss HIV prevention and address HIV misinformation, stigma and discrimination.
- Embedded within a package of HIV services and delivered primarily through civil society organization-led drop-in centers (DICs) for key populations, LINKAGES Kenya supported peer education programs targeting key populations beginning with 15 implementing partners in 11 counties in 2016, and later expanded to 25 partners in 17 counties. Each implementing partner develops and implements activities that would help address structural barriers to access services by key populations, particularly gender-based violence, including sensitization of program staff and peers on how to identify and report incidents of gender-based violence.
- KRCS has conducted ‘Know your Rights’ campaigns through networks of people living with HIV and key population organizations (in Mandera, Garissa, Wajir, Kitui, West Pokot, Tana River, Kiambu, Samburu, Elgeyo Marakwet, Turkana, Kwale and Taita Taveta counties) and organizations of adolescents and young people (in Kisii, Siaya, Machakos, Turkana and Kilifi counties). According to the KRCS, these campaigns had reached 34,000 people as of December 2020. Key population organizations such as the Gay and Lesbian Coalition of Kenya (GALCK) have also produced and disseminated ‘Know Your Rights’ materials specific to the LGBTQ community in Kenya.

Progress to address the recommendations in the MTA report has been good as illustrated in the table below:

MTA Recommendations	Implementation status		Comments
	YES	NO	
<ul style="list-style-type: none"> • Map legal literacy efforts related to HIV, TB, malaria, and key and vulnerable populations undertaken by organizations across Kenya to better coordinate and 		X	<ul style="list-style-type: none"> • With the exception of the mapping of organizations implementing malaria programs by KENAAM, it does not appear that the mapping of legal literacy efforts related to HIV, TB and malaria has been undertaken.

plan legal literacy activities and to identify opportunities to integrate efforts into HIV, TB and malaria services or programs.			
<ul style="list-style-type: none"> Support capacity building of HIV, TB and malaria stakeholders and key and vulnerable population led networks to carry out legal literacy training (including in existing HIV, TB and malaria programs), and provide resources for them to sustain and scale up training of peer educators. 	X		<ul style="list-style-type: none"> KRCS and NSDCC have engaged in the training of HIV and TB stakeholders and key and vulnerable population led networks to carry out legal literacy using peer educators and paralegals and KRCS is providing both technical and financial support to its KP-led SRs to scale up legal literacy programs. Support for legal literacy in the context of malaria appears to have received less attention.
<ul style="list-style-type: none"> Develop user friendly legal literacy resources on human rights, access to justice and legal services for people living with HIV, TB, malaria and key and vulnerable populations for use by peer educators. 	X		<ul style="list-style-type: none"> KRCS has developed digitalized legal literacy materials for people with disabilities and has provided training to 160 people living with disabilities to use these materials to conduct legal literacy programs with people with disabilities in their communities. Provision has been made in the GC7 FR for the further updating and development of user-friendly legal literacy materials.
<ul style="list-style-type: none"> Support nationwide and county specific legal literacy campaigns designed to increase public awareness of HIV, TB, malaria, key populations, gender equality and human rights. 	X		<ul style="list-style-type: none"> Both nationwide and county-specific legal literacy campaigns are being conducted which are designed to raise public awareness about HIV, TB, malaria, key populations, gender equality and human rights. For example, KRCS and its SRs conduct biannual community dialogues with cultural leaders and community elders and members are also conducted by KRCS and its SRs on negative social and gender norms and human rights violations as well as quarterly campaigns on specific legal literacy topics.
<ul style="list-style-type: none"> Develop monitoring and evaluation tools to routinely assess effectiveness of and impact of legal literacy efforts disaggregated by sex, gender identity and sexual orientation, and 		X	<ul style="list-style-type: none"> As is the case with all areas of programming to address human rights and gender related barriers to HIV, TB and malaria services, the development of M&E tools to assess the effectiveness and impact of legal

adjust these efforts as necessary.			literacy efforts has not been done and requires urgent attention.
------------------------------------	--	--	---

Progress on the implementation of legal literacy programs since the MTA include the following:

KRCS and its 62 SRs conduct know your rights campaigns in all 47 counties (compared to only 21 counties under GC5) targeting PLHIV, AGYW, and key and vulnerable populations. Different interventions are designed for rights-holders and duty bearers respectively. Legal literacy is integrated into all community outreach activities under AYP, KP and PMTCT programs by paralegals, community facilitators and Stop GBV Champions and the focus of the legal literacy varies from county to county based on issues that are pertinent for each county. For example, the focus in 6 counties is on AGYW and GBV, given the high rates of teenage pregnancy and GBV in those counties.

Whilst all legal literacy programs provide information on the human rights of the target audiences as well as where to seek assistance if their rights are violated and linkages to legal services, the focus of the legal literacy content differs between various target audiences. For example AYP and AGYW legal literacy focuses on sexual and reproductive health and rights and GBV, whereas PLHIV legal literacy places more of a focus on HIV-related stigma and discrimination in various settings.

Whilst data on the coverage of the KRCS legal literacy programs are limited, quarterly reports for the period January to June 2022 indicate that in the North Rift Region 14972 people were reached with Know Your Rights Campaigns (KYRC) during KP, AYP and PMTCT outreaches and 903 cases were reported to and addressed by paralegals. During the same period 194 people were reached with Know Your Rights Campaigns (KYRC) during KP, AYP and PMTCT outreaches, 40 were reached through Legal Aid clinics and 168 cases were reported to and addressed by paralegals in the Upper Eastern Region.

KRCS has also partnered with the Kenya Union of the Blind to digitalize legal literacy materials in order to make these materials accessible to people with disabilities. It has also provided training for 160 people with different disabilities from ten different organizations on legal literacy and has provided them with the digitalized materials to conduct legal literacy programs for people with disabilities in their communities.

In addition, KRCS has developed a free mobile app called HakiPlus that contains legal literacy information and is accessible to anyone with a mobile phone.

Biannual community dialogues with cultural leaders and community elders and members are also conducted by KRCS and its SRs on negative social and gender norms and human rights violations with a view to improving access to justice. Specific issues addressed in these dialogues include HIV-related law and human rights, stigma and discrimination its impact on treatment uptake and adherence, the provisions of the HIV Prevention and Control Act (HAPCA) and the provisions of the Sexual Offences Act. In addition, KRCS conducts quarterly legal literacy campaigns on specific legal literacy topics.

Legal literacy materials that are specific to the LGBTI community have been developed by galck+ for use by KP-led organizations. These are also available on the galck+ website⁶⁵. Both HAPA Kenya and Amkeni (LGBTI – led organizations and KRCS SRs) provide legal literacy for members of the communities at their drop-in centers and clinics in Mombasa and Kilifi county respectively.

Reachout Centre Trust (a KRCS SR) conducts legal literacy programs for people who use drugs through their paralegals at five drop-in centers and 160 hot spots in 4 counties (Mombasa, Lamu, Kwale and Taita Taveta).

Recommendations

It is recommended that the following be undertaken:

- Develop monitoring and evaluation tools to routinely assess not only the reach and coverage of but also the effectiveness and impact of legal literacy efforts disaggregated by sex, gender identity and sexual orientation, and adjust these efforts as necessary.
- Map legal literacy efforts related to HIV, TB, malaria, and key and vulnerable populations undertaken by organizations across Kenya to better coordinate and plan legal literacy activities and to identify opportunities to integrate efforts into HIV, TB and malaria services or programs.
- Support capacity building of HIV, TB and malaria stakeholders and key and vulnerable population led networks to carry out legal literacy training (including in existing HIV, TB and malaria programs), and provide resources for them to sustain and scale up training of peer educators.
- Develop user friendly updated legal literacy resources on human rights, access to justice and legal services for people living with HIV, TB, malaria and key and vulnerable populations for use by peer educators.
- Support nationwide and county specific legal literacy campaigns designed to increase public awareness of HIV, TB, malaria, key populations, gender equality and human rights.
- Translate the HakiPlus App content into multiple languages to make it more accessible to a wider audience.
- Consider integrating subject matter on human rights in the context of health in secondary school curricula.

(d) Increasing access to justice

HIV program area	Score		
	Baseline (2021)	Mid-Term (2022)	Progress (2023)
Increasing access to justice	2.5	3.5	4.0

As noted in the MTA, paralegal training is a major component of legal service provision for people living with HIV and key populations in Kenya, and there are a range of

⁶⁵ <https://galck.org/know-your-rights/>

organizations across Kenya that have trained paralegals on various human rights issues, though fewer with a specific focus on HIV or TB. Addressing a concern expressed at baseline regarding the lack of standardization, scale-up and support for paralegal training, the KRCS has worked with the paralegal support network (PASUNE) to integrate issues of health, human rights and key populations into its community paralegal workers' training manual — itself intended to standardize the content and methods of paralegal training in Kenya.

Between 2017 and 2021, when the MTA was conducted, NASCOP had trained more than 395 key population paralegals on HIV and human rights. These paralegals formed part of crisis management teams also comprised of an advocacy officer and an outreach worker situated with 32 implementing partners under GC5, such as KELIN and Kituo cha Sheria in 47 counties to respond to human rights violations against key populations under the supervision of a legal practitioner of Kenya's High Court.

With Global Fund support, the KRCS also trained 310 community paralegals under GC5 in 18 counties who respond to cases of human rights violations against key populations and people living with HIV through legal counselling, alternative dispute resolution, arbitration and referral to *pro bono* lawyers and relevant institutions. The paralegals are linked to *pro bono* lawyers and senior paralegals for mentorship and support. Additionally, a total of 35 paralegals (12 people living with HIV and 23 who identify as members of key populations) were linked to the Court Users' Committees in their counties, enhancing paralegals' understanding of the committees' mandate.

As noted in the MTA, NASCOP reported an increase in the number of cases of violence reported by female sex workers from 3600 in 2017 to 7000 in 2020, which they attributed to increased access to paralegals and increased capacity of law enforcement to respond to such cases.

Progress on implementation of the MTA recommendations has overall been good:

MTA Recommendations	Implementation status		Comments
	YES	NO	
<ul style="list-style-type: none"> Support the scale up of peer paralegal training and develop a curriculum on HIV, TB, malaria, key populations, gender equality and human rights to incorporate in the diploma based paralegal training program, in collaboration with people living with HIV, TB and malaria and key population organizations. 	X		<ul style="list-style-type: none"> Partial: Paralegal training has been scaled up. However, as paralegals are able to assist clients without obtaining the paralegal diploma, it has been decided not to pursue the incorporation of HIV, TB, malaria, key populations, gender equality and human rights into the diploma based paralegal training programme.
<ul style="list-style-type: none"> Develop a curriculum for law students and lawyers 		X	<ul style="list-style-type: none"> This has not been achieved to date.

on HIV, TB, malaria, key populations, gender equality and human rights in collaboration with people living with HIV, TB and malaria and key population organizations, incorporate this in the curriculum of the Kenya School of Law, and employ this curriculum for training of new pro bono lawyers.			
<ul style="list-style-type: none"> Establish and support virtual networks of paralegals and pro bono lawyers representing people living with HIV, TB, malaria and key and vulnerable populations to promote knowledge exchange and mutual support, ensuring there are peer paralegals representing people who use drugs and transgender people. 		X	<ul style="list-style-type: none"> While the assessment did not identify such virtual networks, KRCS supported paralegals do have regular meetings with pro bono lawyers to exchange knowledge and address problems encountered, including peer paralegals from PWUD and TG people.
<ul style="list-style-type: none"> Provide support to pro bono lawyers to cover ancillary costs of representing claimants before the HIV and AIDS Tribunal and representing people living with HIV, TB, malaria and key populations challenging human rights violations in other judicial settings (including in pursuit of damages before the High Court). 		X	<ul style="list-style-type: none"> This has been budgeted for in GC7.
<ul style="list-style-type: none"> Continue to promote awareness of the HIV and AIDS Tribunal among county level community leaders and peer paralegals, including on the option of making referrals from local alternative dispute resolution mechanisms (e. chiefs, 	x		<ul style="list-style-type: none"> Both HAT and NSDCC have conducted large scale awareness programs about HAT through social media and videos.

police, village elders, county council askaris).			
<ul style="list-style-type: none"> Expand options to facilitate access to the HIV and AIDS Tribunal, including via additional teleconferencing facilities, satellite sites and mobile courts, and identify and equip organizations to facilitate local teleconferencing with community members requiring access to the Tribunal. 	x		<ul style="list-style-type: none"> Four new teleconferencing facilities have been established in Meru (supported by the Global Fund), Mbita, Kericho County and Garissa (the latter three being supported by UNDP). HAT trains paralegals on the provisions of HAPCA, the processes and procedures of the Tribunal and how to use the teleconferencing facilities.
<ul style="list-style-type: none"> Ensure accessibility of psychosocial support and effective, permanent pro bono legal counsel at the HIV and AIDS Tribunal. 	x		<ul style="list-style-type: none"> Partially: Although HAT does not have the budget to employ permanent pro bono counsel, it has entered into an MoU with Next Gen Lawyers for the provision of pro bono legal services at the Tribunal. A system is also in place to refer complainants who need it to psychosocial support.
<ul style="list-style-type: none"> Amend the HIV and AIDS Prevention and Control Act to empower the HIV and AIDS Tribunal to order execution of payment upon judgment. 		X	Although amendments to the HIV and AIDS Prevention and Control Act are being considered, this has not happened to date.

Progress since the MTA:

There has been substantial progress in increasing the scale and coverage of the majority of programs to increase access to justice in respect of HIV-related human rights violations.

Paralegal training and support

In the period since the MTA, NASCOP and KRCS have both continued to train paralegals. KRCS has contracted the Legal Resources Foundation, which also houses the Paralegal Society of Kenya (PSK), to conduct their paralegal training. The KRCS paralegal training course is tailored for different groups of peer paralegals (LGBTI, SW, PWUD). It is for a period of 21 days which comprises an initial eleven-day period of training, followed by a period of practicals, which affords trainees to gain on the job experience, followed by a further ten-day period of training. KRCS has also provided training for the TB Champions on HIV-related law and human rights. The paralegal training offered by NASCOP, on the other hand, is only for a period of five days. It appears then that paralegal training is not standardized. No data were available on the numbers of paralegals trained by either KRCS or NASCOP in the period since the MTA.

In addition to training paralegals, KRCS has also conducted training in the first half of 2023 of the project leads of the SRs who are responsible for supervising paralegals in order to address the fact that the project leads often have little knowledge or understanding about how the paralegal model operates, thus rendering them less effective when it comes to the provision of support required by paralegals in order to be effective in their work. To address this identified gap, KRCS conducted a three-day training for project leads on the paralegal model. The training covered the following topics:

- An overview of Witness Protection law and work in Kenya
- Paralegals and access to justice;
- Code of Conduct for paralegals;
- Understanding of the paralegal model – practical application of the concept in the context of KRCS Human Rights Program
- Report & Concept writing;
- Reimagining the paralegal model in the context of KRCS Human Rights Program – reimagining targeting for paralegals and their clients, facilitation, and networking/ pathways for referral in the paralegal context;
- Reimagining and visioning for human rights institution building in the humanitarian work context, and;
- Understanding of the PSK structure, constitution and linkage with paralegalism⁶⁶.

Good Practice: Mentoring of Paralegals

NextGen Lawyers provides support and training for MSM, SW, transgender and PWUD peer paralegals and take a different, more innovative approach to this training. They provide training after paralegals have completed the paralegal training offered by KRCS and NASCOP with a view to making the paralegals more self-sufficient in respect of legal assistance by building their skills to handle matter that are referred to them on their own rather than referring all cases on to pro bono lawyers. They achieve this through on the job mentoring of paralegals by lawyers.

Paralegals engaged by KRCS KP-led SRs provide their services through outreach activities and at hot spots and drop-in centers. Those that are engaged by KRCS SRs that work with AYP provide targeted legal aid clinics, together with pro bono lawyers for PLHIV, AYP, AGYW and other vulnerable populations to promote awareness and address cases of human rights violations.

According to data provided by KRCS during this assessment, KRCS SR paralegals resolved a total of 142 cases by way of alternative dispute resolution during 2022 and an additional 30 cases were referred to the courts.

Resolved through ADR	
Verbal abuse of PLHIV and KPs	32
Outing of being an MSM or SW by family or community	4
Assault (SOGI 10) (SW 2)1	12
Blackmail (HIV status 1) (SOGI 1)	2
IPV (heterosexual)	15

⁶⁶ KRCS GF LER Quarterly report Jan to June 2023

IPV (MSM)	4
Harassment (MSM)	2
Sexual harassment (MSM)	1
Cyber bullying (MSM)	1
Disapproval / harassment of MSM by family	2
Eviction of TG from family home	1
Threats of violence against MSM by community	1
Workplace S&D (MSM 2) (SW 1) (HIV 2)	5
Unlawful arrest (KP)	2
Accusation of recruiting young MSM on town whatsapp group	1
Closure of SW hotspots and "sex dens" by District County Commissioner	1
Assault and non-payment of sex worker by police client	1
Threat to evict women living with HIV from her home	1
Illegal use of land belonging to HIV+ minor	1
Illegal claim on land inherited by widow living with HIV and children by late husband's family	3
Denial of inheritance on basis of HIV status	2
Eviction of women living with HIV in discordant relationship by husband from common home	2
Abandonment of wife by husband due to her HIV status	1
Termination or refusal of lease on basis of HIV status	4
HIV-related stigma and discrimination in the community	1
Disclosure of HIV status by family or neighbors	6
Wife inheritance	1
Defilement of minors	2

The most common type of case resolved through ADR is verbal abuse (32), followed by IPV within heterosexual couples (15) and assault of PLHIV and KP members (12). It is noteworthy that not one of the cases resolved through ADR related to stigma and discrimination in health care facilities. Of concern is the fact that so many cases of IPV are resolved through ADR. Although this may offer a speedy resolution for women seeking justice, ADR may also lead to further violations of their rights and impunity for perpetrators because they often operate on the basis of patriarchal values, thereby having a negative impact on women's access to judicial review and remedies. It is thus critical that paralegals are careful to ensure that women who are survivors of intimate partner violence are not prevented through ADR from seeking judicial remedies as a result of patriarchal values⁶⁷.

Also of concern is the fact that a number of cases resolved by paralegals through ADR do not appear to relate in any way to human rights and gender barriers to access to HIV, TB and malaria services.

By way of example, according to the KRCS data accessed in the course of this assessment the following types of cases were taken on and resolved by paralegals by way of ADR:

- Theft of household equipment and of water pipes

⁶⁷ See 58 (c) Committee on the Elimination of Discrimination against Women, General recommendation No. 33 on women's access to justice.

- Pressure being placed on bisexual person to marry by the female partner
- Theft by a sex worker from a client who retaliated by biting her tongue
- Adultery
- Fighting between wives
- Injury from being hit by a drunken driver
- Non-payment of workers
- Unauthorized grazing on land
- Theft of a sex worker's phone charger by another sex worker

Of the 30 cases referred by paralegals for resolution by the courts, the majority of these were defilement cases (12), followed by disclosure of HIV status by family or community members (3) and child custody cases where the mother is living with HIV (2). Other cases referred by paralegals to the courts include rape of a sex worker by clients (1), harassment and outing of an MSM by police to the community (1), child marriage (1), IPV (1) and child abuse (2). Similar to matters resolved through ADR, several of the cases referred to the courts, including cases of child maintenance and land disputes, appear to be unrelated to addressing barriers to access to HIV, TB and malaria services.

This would appear to point to the need to ensure that the training of paralegals provides them with adequate information on the types of cases that they should taking on.

KRCS supported paralegals meet at the regional level with program officers from the SRs, the pro bono lawyers and local court officials on a biannual basis to share and discuss their challenges and lessons learned during their engagement with clients, to share success stories and best practices for documentation and to provide suggestions and recommendations for improvement⁶⁸ They also participate in the Court User's Committees, a forum that brings together actors in the administration of justice as well as users in the justice system to address problems within the sector by all agencies and stakeholders concerned. CUCs also serve to promote accountability and improvement of performance by Courts and all actors within the justice chain⁶⁹.

KRCS paralegal success stories⁷⁰

Obama who works as a mason at a construction site in Mandera town narrates his story of how he lost his job because of his HIV status and was reinstated through the support of a paralegal affiliated to a PLHIV network. One day at work he misplaced his health card and in the process of searching for it, his colleagues together with the foreman found out that he was HIV positive. After that they refused to share work tools with him and ultimately the foreman decided to terminate his services simply because he could not bear working with someone who is HIV positive.

"I gave up and I wanted to leave Mandera because of the harrowing experience at the hand of the colleagues and foreman, I raised bus fare just to travel back to Siaya County "I heard of Asnath a community paralegal who undertakes and follows up human rights violations against

⁶⁸ KRCS GF Quarterly report Jan to June 2023 UER

⁶⁹ For more information on the Court User's Committees see https://www.law.berkeley.edu/wp-content/uploads/2015/10/Kenya_NCAJ_Court-Users-Cmte_brochure.pdf

⁷⁰ <https://referraldirectories.redcross.or.ke/?p=1615>

PLHIVs and that's how I decided to look for her number and give her a call for support", says Obama.

When the paralegal received the violation report she visited the foreman and explained that by firing Obama on the basis of his HIV status he had violated his human rights. She was invited back to the construction site after that to talk to the laborers and used this opportunity to create awareness on HIV, modes of transmission and prevention and the negative impact of stigma and discrimination.

The paralegal had this to say, "I thought it was wise to first approach the issue in this manner before taking the legal way, this is because, from what was shared by my client, Mr. Obama, it was clear that the foreman and the colleagues had very little knowledge on HIV and instead believed in myths."

As a result of the paralegal's intervention, not only was Obama reinstated in his job but his colleagues were equipped with information on HIV, stigma and discrimination.

"The FSW hotspots & sex dens were all closed by the district county commissioner (DCC). The DCC said he does not allow sex work in Kisii, as it is illegal and no sex den will operate. As a paralegal I visited the DCC and explained by closing hotspot the FSW will default the prevention measures which will lead to rise of HIV infection, again it is easy to manage GBV when they are in a respective sex den, we came to an agreement, where he allowed me to open up the hotspots and sex dens, and now he is a member of our advocacy."

Advice and reporting hotlines

Under GC5, NASCOP's 32 implementing partners also coordinated key population-run hotlines for members to report incidences of violence and call for legal advice. A protocol for the hotlines was implemented in 2017, using platforms such as WhatsApp. At the time of the MTA there were more than 20 active groups that reported and responded to cases. Sadly, at the time of this assessment it appeared that with the exception BHESP, which operates an SMS emergency service for SW, that provides information and access to a local peer paralegal, few, if any of these original hotlines continue to operate.

Training and support for pro bono lawyers

At the time of the MTA, KRCS maintained a database of *pro bono* lawyers willing to provide HIV-related legal services. KELIN also had a network of *pro bono* lawyers who are willing to work on HIV- and TB-related cases and offers legal aid clinics in different settings targeting key populations, including legal aid clinics at some methadone clinics, providing an opportunity to integrate legal aid and health services. As with paralegals, the MTA noted a frequent turnover of lawyers who had been sensitized on HIV and human rights, and there is a need to offer continued support and training. During GC5 NASCOP also worked with the Law Society of Kenya, which requires every legal practitioner to take at least two cases annually *pro bono*, to coordinate potential lawyers to take up various cases on behalf of people living with HIV and key populations.

Since the MTA, both KRCS and NASCOP have continued to identify, train and maintain databases of pro bono lawyers. In addition, pro bono lawyers like NextGen Lawyers, provide pro bono legal representation for complainants at the Tribunal and to enforce civil damages orders made by the Tribunal in terms of an MoU they have concluded with the HIV and AIDS Tribunal.

Curriculum for law students

Under GC5 NASCOP also engaged the Kenya School of Law to increase the understanding of law students and future lawyers on HIV and human rights and approached the Council of Legal Education to incorporate this information in its curriculum. At the time of this assessment, this had yet to be formalized.

Online directory of legal and social services

KRCS has also, since the MTA, developed an online referral directory of both social and legal services, with a view to improving access to both. The online directory is easy to navigate and features drop down menus in respect of the geographic area and the type of services that are being sought⁷¹. It is also available as a mobile app.⁷²

The legal support services listed in the online directory include the provision of legal information, as well as links to legal, psychosocial and other support and pro bono services including legal counselling, litigation and legal representation. These include:

- GBV prevention and responses initiatives.
- Integrated services for SGBV survivors
- Support for GBV survivors, psychosocial Support
- Linkage to safe house and, temporary shelters for GBV survivors.
- Rehabilitation of non-custodial offenders.
- Harm reduction referrals.
- Collection of specimens for screening for GBV.
- Alternative Community dispute and conflict resolution.
- Support for legal aid and litigation

HIV and AIDS Tribunal

Established under Section 25 of the HIV Prevention and Control Act of 2006 (HAPCA), the HIV and AIDS Tribunal of Kenya is the only HIV-specific statutory body in the world with the mandate to adjudicate cases relating to violations of HIV-related human rights. The tribunal is granted a broad mandate to “hear and determine complaints arising out of any breach of the provisions of the Act.”⁷³

Since the MTA there has been good progress in making the Tribunal more accessible to complainants through the addition of four new teleconferencing facilities in Meru (supported by the Global Fund), Mbita, Kericho County and Garissa (the latter three being supported by UNDP). Thus, the Tribunal is now accessible in Nairobi, where it

⁷¹ https://referraldirectories.redcross.or.ke/?page_id=1625

⁷² https://files.appseyser.com/Red%20Cross%20Referral%20Directories_17204657.apk

⁷³ s26(1)(a) of HIV Prevention and Control Act of 2006

has its physical seat and in seven counties through teleconferencing. In addition to hearing matters brought before it, Tribunal secretariat staff engage in nationwide awareness raising about the Tribunal and also train paralegals on the provisions of HAPCA, the processes and procedures of the Tribunal and how to use the teleconferencing facilities. Despite the training of paralegals, the Tribunal CEO has noted that very few cases are referred to the Tribunal by these paralegals⁷⁴.

NSDCC has also engaged in raising awareness about HAT and the other different avenues of legal support that exist in the context of both HIV and TB, including the HAT, paralegals and pro bono lawyers among PLHIV & TB, key and vulnerable populations and community gatekeepers. In the first quarter of 2023 this included a social media campaign on Twitter and Facebook about the HAT as well as the publication of a bulletin covering the work of the Tribunal and the achievements so far and a video production of success stories from the users of the HAT.

In addition to training paralegals, HAT has a memorandum of understanding with Strathmore University in Nairobi in terms of which HAT hosts 2 students a year from the University so that the students can learn from the work of the Tribunal and improve their understanding of HIV, law and human rights.

They have also partnered with a university law clinic to develop a Tribunal Users Handbook, which will further facilitate access to the Tribunal. In addition, HAT has developed a Registry Manual for complainants as a guide to enable them access the Tribunal services easily.

Unlike the mainstream judiciary, which charges for use of the Judiciary E-filing system, HAT has been zero-rated on the Judiciary E-filing system, which enables complainants both to file claims at the Tribunal, (by way of a letter; email; call or filling in a form available on their website) as to well as file remotely through the E-filing system at no cost.

Similar to other Judiciary units/courts, the Tribunal has signed a performance contract with the Judiciary Directorate of Planning, Organizational and Performance (DPOP) headed by the Chief Justice and at the end of every financial year, the Tribunal is assessed and given feedback to ensure that they offer quality services and expeditious delivery of justice for their clients.

As noted in the MTA, while the number of cases reported to the Tribunal had been increasing since 2015 (with the highest number reported in 2019), the Tribunal only received 50 cases in 2020, reflecting a decline during the COVID-19 pandemic. During the period May 2022 to April 2023 the Tribunal was unable to sit as the terms of its members had expired and delays caused by the national election in August 2022 and the change of regime meant that new members were only appointed by the Attorney General in March 2023. As a result, in 2022 the Tribunal only heard 37 matters, of which the majority (19) related to stigma and discrimination in community settings, followed by 9 related to stigma and discrimination in health care facilities, 5 related to

⁷⁴ Key Informant Interview with Tribunal CEO, June 2023

stigma and discrimination in family settings, and 4 related to stigma and discrimination in workplace settings.

As at October 2023, it has heard 57 matters of which by far the majority (32) are related to stigma and discrimination in community settings, followed by 13 related to stigma and discrimination in family settings, 11 related to stigma and discrimination in workplace settings and only 1 in health care settings⁷⁵. According to the Tribunal CEO the number of cases related to stigma and discrimination in workplaces has significantly reduced over the years.

One of the challenges currently faced by the Tribunal is that it does not have the power to enforce its own judgments for payment of damages and this must be done before the civil division of the High Court, which does not automatically link claimants with *pro bono* lawyers. There are also court fees involved and as clients are often not in a position to pay these, *pro bono* lawyers pay these out of their own pockets. As noted earlier however the Tribunal does now have a memorandum of understanding with NextGen Lawyers to assist with the enforcement of Tribunal judgments in the High Court on a *pro bono* basis.

Dialogue with and resources for the judiciary

Since the MTA, NSDCC (formerly NACC) has hosted a dialogue between 21 Judges from the Employment and Labor Relations Court and representatives of Key Populations and PLHIV. The dialogue covered several topics including stigma and discrimination in the workplace, HIV and labor rights and the role of judges in the HIV response. Key recommendations from the meeting were:

- To ensure an increased understanding of the HIV epidemic and the overarching policy document that guide the HIV response in the country among more members of the judiciary, engagement with another grouping of judges was proposed.
- Following discussions, it was noted that most of the interaction of key populations with the courts occurs at the Magistrate Courts' level and thus future dialogue should take place with magistrates. It was thus recommended that there should be further engagement between the NSDCC and other groupings of judiciary officers, including Magistrates, who encounter HIV-related matters prior to the matters being referred to the High Court.

In addition, as a result of a continued partnership between the Kenya Magistrates and Judges Association (KMJA) and Initiative for Equality and Non Discrimination⁷⁶ that started in 2021, over 90 judicial officers have taken part in transformational dialogue and collaborative workshops on the jurisprudence for the protection of the human rights of sexual and gender minorities in different parts of the country.

Engagements with the judiciary have also taken place at the regional level. In Meru, the KRCS regional office and the local SR (HWWK) visited the office of the presiding judge at the Meru law court, who is also the presiding judge at a number of courts in the region including the Marsabit, Maralal, Chuka, Embu, Nanyuki, Meru law courts. The purpose of this engagement in the first quarter of 2023 was to introduce the

⁷⁵ Data provided by HAT CEO to the assessment team 30 October 2023

⁷⁶ A Kenyan community-led organization that champions justice and equity for sexual and gender minorities in Kenya

access to justice program under GC5, to discuss and attempt to identify solutions to challenges faced by paralegals in bringing cases to the courts and to improve linkages between the paralegals and the courts in the region. The Presiding Judge noted that prior to this engagement the court did not have a clear understanding of the program and that in his view it provided a good opportunity for partnership in support of communities to pursue justice and to provide a link between the bench and the community. It was thus agreed that there would be regular meetings between high court judges, magistrates, ODPP, selected paralegals, pro-bono lawyers and some program staff in the Upper Eastern Region on a semester basis with a particular focus on GBV cases with a view to strengthening the working relationship between courts and the access to justice program, thereby enabling the courts to refer GBV complainants who require assistance to the paralegals and for both parties to identify mechanisms for improving community support for the reporting of GBV cases⁷⁷.

A new resource for the judiciary was published in 2023 by the Initiative for Equality and Non-Discrimination with support from the Arcus Foundation. Entitled “A Legal Resource Guide: Implementing LGBTIQ+ Human Rights in Kenya” this bench book displays how cases involving these minorities are handled, argued, and settled by providing details on past cases and the jurisprudence employed in them. This publication is timely given the recent tabling of the Family Protection Bill, which, if passed into law, will further criminalize same sex sexual relationships and exacerbate the existing severe barriers to access to services for MSM and TG, in addition to increasing threats to their safety and security.

Gaps and challenges

This assessment noted the following gaps and challenges in access to justice programming:

- There continues to be a high turnover of paralegals and pro bono lawyers trained on HIV and Human Rights and there is thus an ongoing need for training of both paralegals and pro bono lawyers.
- Paralegal training is not standardized (e.g., NASCOP’s paralegal training is for 5 days whereas KRCS paralegal training is for 21 days) – there is a need to review and standardize paralegal training curricula.
- Many cases of IPV reported to paralegals are resolved through ADR. Although this may offer a speedy resolution for women seeking justice, ADR may also lead to further violations of their rights and impunity for perpetrators because they often operate on the basis of patriarchal values, thereby having a negative impact on women’s access to judicial review and remedies. It is thus critical that paralegals are careful to ensure that women who are survivors of intimate partner violence are not prevented through ADR from seeking judicial remedies as a result of patriarchal values⁷⁸.
- A number of cases resolved by paralegals through ADR do not appear to relate in any way to human rights and gender barriers to access to HIV, TB and malaria services.

⁷⁷ KRC UER Progress report Jan to June 2023

⁷⁸ See 58 (c) Committee on the Elimination of Discrimination against Women, General recommendation No. 33 on women’s access to justice.

- Paralegals and others providing community based legal services do not have access to sufficient psycho-social support. This is also the case for HAT complainants.
- Despite engagement by NASCOP under GC5 with the Kenya School of Law and the Council for Legal Education to incorporate HIV, TB, law and human rights into the law school curriculum, this has yet to happen.
- Sensitization on HIV, TB, human rights and the law has yet to reach many members of the judiciary.
- HAT does not have the power to enforce its own judgments for damages and as a result pro bono lawyers representing clients in the enforcements of their judgments in the High Court often have to pay the court costs and other ancillary costs out of their own pockets. There is inadequate funding support for pro bono lawyers to cover these costs and this deters lawyers from assisting on these matters on a pro bono basis.

Recommendations

The following actions are recommended:

- Make provision for ongoing training of both paralegals and pro bono lawyers and ensure that paralegals are paid a reasonable stipend and that payment of court fees and ancillary costs are covered by funding to reduce the high turnover of paralegals and pro bono lawyers.
- Review the curricula of NASCOP and KRCS for paralegal training and standardize the curriculum for use across the board.
- Ensure that IPV survivors are advised by paralegals of their right to have cases of IPV and GBV prosecuted and that ADR only be employed with the specific consent of the IPV survivor, their options having been fully explained to them. Where ADR is employed, ensure that the survivor's right to justice is not compromised.
- Ensure that the paralegal training curriculum is clear on the types of cases that are to be taken on by paralegals to address human rights and gender barriers to access to HIV, TB and malaria services.
- Consider the provision of psycho-social support, in the form, for example, of opportunities for debriefing sessions as a standard part of paralegal programming.
- Ensure that HIV, TB, law and human rights is incorporated into the law school curriculum.
- Foster increased collaboration with universities and law clinics to expand the development of educational resources to facilitate better access to the tribunals for KP.
- Scale up activities to sensitize members of the judiciary on HIV, TB, human rights and the law.
- Strengthen regional engagement with judges across the region for peer to peer learning for members of the judiciary to ensure a broader understanding and commitment to human rights in the context of HIV, TB, and malaria.
- Advocate for the amendment of HAPCA to afford HAT the power to enforce its own judgments for damages. Alternatively ensure that provision is made for funding to cover the court and other ancillary costs associated with enforcing the judgment in the High Court.

- Provide support for the provision of psychosocial support to HAT complainants either through the employment of relevant staff at the Tribunal or through the establishment of a formal referral system to existing services.
- Develop monitoring and evaluation tools to routinely assess not only the reach and coverage of but also the effectiveness and impact of programming to increase access to justice.

(e) Ensuring rights-based law enforcement practices

HIV program area	Score		
	Baseline (2021)	Mid-Term (2022)	Progress (2023)
Ensuring rights-based law enforcement practices	2.0	3.0	3.3

As noted in the MTA various human rights abuses inflicted against key populations in Kenya by law enforcement officers and county government workers have been documented by numerous actors and these continue to occur. They include reports of police harassment, extortion, arrests and verbal and physical abuse (sometimes targeting patients of health care clinics), raids of organizations offering key population services, and inhumane and degrading treatment, including denial of or limited access to treatment while in police custody and in prison. In July 2022 Kenya Police Service officers closed down a meeting of the Key Populations Consortium of Kenya meeting in Malindi and unlawfully arrested and detained five key population leaders who were advised by Police Service officers that communities of Key Populations must notify the Kenya National Police Service - AIDS Control Unit of any gathering by community members, given their status as criminalized populations – a requirement that had never been in place previously⁷⁹.

Under GC5 there were various efforts both by state and non-state actors to sensitize police service and prison service members on the rights of key populations, on HIV, TB, law and human rights and on the impact of failure to implement rights-based law enforcement on the response to HIV and TB. NACC (now NSDCC) and NASCOP published a manual in 2016 entitled 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 to train trainers to teach law enforcement officers to exercise discretion when responding to incidents involving key populations and to practice rights-responsive policing, and in collaboration with the AIDS Control Unit of the Interior Coordination Ministry and other partners, trained 300 trainers on the manual, across 47 counties, following which more than 4200 officers were subsequently sensitized. Working with the Interior Coordination Ministry, NASCOP also trained more than 400 law enforcement officers (over a five-day course of training) and sensitized more than 4000 law enforcement officers and 200 recruits (over a 1-2 day workshop) on HIV, stigma and discrimination, gender-based violence, and human rights violations. In-service training was also provided to officers on violence prevention and response in counties where research has shown this to be particularly prevalent. However, at the time of the MTA, a curriculum on HIV, TB, law

⁷⁹ Key Informant Interview KP Consortium June 2023.

and human rights had yet to be incorporated into pre-service training and as noted by the MTA many of these interventions were conducted largely on an ad hoc basis targeting individual police stations. In addition, there were no monitoring and evaluation systems in place to measure the impact of these interventions.

Progress to implement the MTA recommendations has been limited:

MTA Recommendations	Implementation status		Comments
	YES	NO	
<ul style="list-style-type: none"> Support civil society and key population led organizations to continue and scale up community led monitoring of human rights violations, including violations perpetrated by law enforcement, and incorporate findings into efforts to sensitize law enforcement and for advocacy purposes. 	X		<ul style="list-style-type: none"> Various KP led organizations are monitoring human rights violations at the hands of law enforcement and are engaged in sensitization of Kenya National Police Service members.
<ul style="list-style-type: none"> Finalize curriculum for preservice training of police on HIV, TB, key populations, gender equality and human rights in collaboration with people living with HIV, TB, gender equality and key population organizations and incorporate training into National Police Service Training Curricula. 		X	<ul style="list-style-type: none"> The curriculum has been finalized but not yet incorporated into pre-service training.
<ul style="list-style-type: none"> Build capacity of police and prison service training facilitators to deliver the HIV, TB, key populations, gender equality and human rights training, including in consultation with people living with HIV, TB, gender equality and key population organizations. 	X		<ul style="list-style-type: none"> This has been undertaken, albeit on a relatively small scale as a result of failure to finalize and incorporate the HIV, TB human rights, gender and law module in pre-service training.
<ul style="list-style-type: none"> Conduct knowledge and attitude assessments of police and prison services on rights of people living with HIV, TB and malaria 	X		<ul style="list-style-type: none"> A knowledge assessment will be undertaken before the end of the GC6 funding period.

and key and vulnerable populations to help determine priorities for ongoing in service training.			
<ul style="list-style-type: none"> Support civil society and key population led organizations to continue and scale up engagement and sensitization of lawmakers at county and national level on HIV, TB, malaria, key populations, gender equality and human rights. 	X		<ul style="list-style-type: none"> Civil society and key population led organizations do engage with lawmakers, albeit on a relatively small scale (see section 3.6 below).
<ul style="list-style-type: none"> Develop monitoring and evaluation tools to routinely assess effectiveness of and impact of law enforcement and lawmaker sensitization efforts, disaggregated based on sex, gender identity and sexual orientation, and adjust these efforts as necessary. 		X	<ul style="list-style-type: none"> Monitoring and evaluation tools have not been developed and there is an urgent need to do so.

Progress since the MTA

Whilst this assessment did identify several interventions which had been implemented since the MTA, overall progress on ensuring rights-based law enforcement practices has been limited.

NSDCC hosted two meetings with a view to building the capacity of police service training facilitators to deliver in service training on HIV, TB and human rights as well as on human rights and gender related barriers to access to HIV and TB services and on GBV/SGBV. The first was attended by 10 participants from the Kenya Prisons Service as well as by representatives from NSDCC, NASCOP and the TB program to discuss barriers to access to HIV and TB services that are particular to the prisons setting. At the second meeting, 24 participants drawn from inmates, prison service staff and their families in eight regions were trained as trainers of peer trainers who will cascade the training down at the participating prisons.

An HIV, TB, human rights and law training module for incorporation in police pre-service training has been developed by NASCOP but to date only pilot training has been conducted using this module in order to test the module with limited participants and the module has yet to be incorporated into the police pre-service training curriculum as it has not been approved by police service senior management. Thus training of police service members is still limited to in-service training conducted by

NASCOP and in-service sensitization, conducted primarily by key population led organizations including BHESP (SW), Men Engage (GBV), Jinsiangu (TG) and Reach Out Trust (PWID) at individual police station level.

There has been good scale up of key population led sensitization of members of the Police Service.

KRCS SRs NOPE and IRDO are implementing prevention programs for PWID in Kericho, Bomet, Nyamira, Vihiga and Busia counties, which include needle and syringe (NSP) programs. The regional KRCS team has supported these SRs to sensitize Police Service and County Commissioner staff on the need to support NSP programs in their counties. This intervention was supported by the relevant County AIDS and STIs Coordinators (CASCOs). The initial activity was sensitizing the leadership of the county security committee on harm reduction interventions for PWID and why they are critical for an effective HIV response. The SRs also used this opportunity to request permission to co-opt a representative of the law enforcers onto the community advisory board (CAB) for these prevention programs for PWID, which was granted. This was followed by a sensitization meeting by NOPE and the MoH with the county commissioners and police commanders in Kericho and Bomet counties. This meeting resulted in NOPE being given the greenlight to start the roll out of the PWID prevention program in these two counties.

A key informant from NSDCC interviewed in the course of this assessment indicated that the current plan is to develop one standardized module on HIV, TB and human rights for integration into the existing curriculum for pre-service training of both the national police and prison services.

To this end two meetings were held with participants drawn from the Police Training College, the Police Headquarters AIDS Control Unit, NASCOP, NSDCC, the TB Program and communities to review the module and to train 26 National Police Service Instructors and Department Heads from the National Police Training College (Kiganjo).

It appeared at the time of this assessment that despite this initiative the standardized module has yet to be incorporated into the Police Service and Prisons Service Pre-service Training curricula and several key informants interviewed during the course of this assessment indicated that developing and implementing a standardized module for incorporation in pre-service training for both the Police Service and the Prisons Service is not a good option as the contexts in which members of the Police Service and the Prisons Service operate are completely different.

Gaps and Challenges

- The training module developed by NASCOP for incorporation in both the Police Service and Prisons Service pre-service training curricula are yet to be approved by Senior Management of the Police and Prisons Services respectively and are thus currently not included in the pre-service training.
- Training of both Police and Prisons Services members is limited to in-service training at individual facility level due to lack of buy-in by senior management of both Services.

- Increasing human rights violations by county askaris⁸⁰, who have not previously been targeted with in-service training, have been observed.
- Neither the impact of, nor the coverage of the in-service training efforts is well evaluated, with anecdotal reports serving as evidence of impact.

Recommendations

There continues to be some progress in the training and sensitization of law enforcers, and monitoring of violations against key populations such as sex workers. However, the Global Fund support to integrate training within pre-service training of the National Police Service and the Prisons Service continues to have limited success, and various challenges remain. In addition, the impact of the in-service training efforts is not well evaluated, with anecdotal reports serving as evidence of impact across various sectors.

To achieve comprehensive programs to ensure rights-based law enforcement practices, the following steps are recommended:

- Develop monitoring and evaluation tools to routinely assess not only the reach and coverage of but also the effectiveness and impact of training disaggregated by sex, gender identity and sexual orientation, and adjust these efforts as necessary.
- Scale up engagement with stakeholders in law enforcement to strengthen their understanding of HIV, TB, key populations, human rights and gender.
- Support community led dialogues with sub county security, NGAOs and Nyumba Kumi⁸¹ to strengthen community- security structures relations.
- Review and update the Police Service human rights training module to reflect results from latest Stigma Index Assessment and knowledge and attitude assessments conducted under GC6 and integrate into pre-service training curriculum.
- Develop a human rights training module for the Prisons Service and integrate this module into pre-service training.
- Undertake a knowledge assessment for county askaris on human rights and gender and rights-based policing to guide the development of an engagement module.
- Develop and implement a county askari training module on rights- based law enforcement in the context of HIV and TB.

(f) Improving laws, regulations and policies relating to HIV and HIV/TB

HIV program area	Score		
	Baseline (2021)	Mid-Term (2022)	Progress (2023)
Improving laws, regulations and policies relating to HIV and HIV/TB	3.0	4.0	4.3

⁸⁰ Askaris are responsible for enforcing county laws and are also known as County Enforcement Officers, County Inspectorate Officers, County *Kanjo*.

⁸¹ Nyumba Kumi Initiative is an approach to policing that brings together the police, civil society and local communities to develop local solutions to safety and security concerns.

As noted in the MTA, civil society organizations had continued to engage in strong national-level advocacy efforts. For example, NEPHAK supported and mentored adolescents, young people and key populations living with HIV to successfully engage in developing the second *Kenya AIDS Strategic Framework* as well as to participate in deliberations on differentiated service delivery, a national dialogue on universal health coverage, and reprogramming negotiations for Global Fund grants. VOCAL Kenya has advocated with members of the Kenya National Assembly and the parliamentary Health Committee on harm reduction and the effect of discriminatory drug laws, while KENPUD has successfully advocated with NASCOP to scale up harm reduction services and successfully engaged the National Agency for the Campaign against Drug Abuse to develop guidelines on sheltering homeless people who use drugs. As part of its advocacy strategy, NASCOP had also engaged national policymakers in reviewing relevant laws and policies such as the HACPA and the *Narcotic Drugs and Psychotropic Substances (Control) Act*.

National advocacy related to the needs of women and girls also remained strong. In 2019, AYARHEP mobilized 500 young women of reproductive age to march in solidarity demanding access to equitable HIV treatment, after which the government invited AYARHEP and other stakeholders to jointly work towards improving universal access to HIV treatment and health care. AYARHEP was also invited to contribute evidence on the needs of adolescent girls and young women, including sex workers, to a reproductive health bill.

The Kenya Key Population Consortium facilitated the participation of key population organizations in global advocacy processes, such as Kenya's Universal Periodic Review process (2018/2019) and shadow reporting to treaty monitoring bodies. As noted at baseline, Kenya's LGBT community has been particularly active in raising concerns under the Universal Periodic Review mechanism, which has led to repeated recommendations from the UN Human Rights Committee that Kenya decriminalize same-sex intimacy between consenting adults.

As also noted by the MTA, strategic litigation had been employed to challenge laws that are perceived to be barriers to accessing HIV, TB or other health services. KELIN, for example, successfully petitioned the High Court of Kenya in 2016 against the isolation of persons suffering from infectious diseases in prisons, and LGBT activists, the Gay and Lesbian Coalition of Kenya (GALCK) and the Nyanza, Rift Valley and Western Kenya Network (NYARWEK) challenged provisions of the Kenyan *Penal Code* criminalizing same-sex conduct – which was dismissed by the Kenyan High Court in 2019. Other cases that remained pending at the time of the MTA included a lawsuit in High Court initiated by five women living with HIV (and supported by KELIN and African Gender and Media Initiative Trust) who were sterilized without their knowledge or consent, and a petition in High Court initiated by five people living with HIV (supported by KELIN) seeking a declaration that provisions of the *Sexual Offences Act*, which criminalize intentional transmission of HIV, are unconstitutional.

Good progress has been made on the implementation of the MTA recommendations:

MTA Recommendations	Implementation status		Comments
	YES	NO	
<ul style="list-style-type: none"> Support the national and county advocacy sub-committees to expand membership to ensure more key population representation and representation from organizations working to address gender inequality, and to meet regularly, engage in advocacy and host national and county dialogues described below. 	X		<ul style="list-style-type: none"> The national and county level advocacy sub-committees continue to exist – it was unclear from this assessment however to what extent they are supported or how regularly they meet.
<ul style="list-style-type: none"> Hold yearly community-led county monitoring and advocacy sessions for people living with HIV, TB and malaria and key and vulnerable populations to share findings from community monitoring with health care providers, policymakers and police to address and remove legal and policy barriers to accessing HIV, TB and malaria services at county level. 	X		<ul style="list-style-type: none"> Community-led county level monitoring and advocacy sessions are held, largely supported the KRCS regional offices.
<ul style="list-style-type: none"> Hold yearly national multi-sectorial human rights dialogues with national policymakers, including members of the Parliamentary Health Committee, health care providers and police to increase their knowledge of human rights issues concerning HIV, TB and malaria and help remove national legal and policy barriers to accessing HIV, TB and malaria services. 	X		<ul style="list-style-type: none"> NSDCC has conducted Multisectoral engagement forums with key actors in HIV, GBV response in year 1 and 2 of GC6 implementation with 30 counties being reached and 1956 participants. The forums aim at bringing together stakeholders to address human rights barriers to access HIV services, stigma & discrimination among key and vulnerable populations, gender discrimination and gender-based violence. <p>The participants comprised Ministry of Interior- National Government Officials (Chiefs), the Gender Desk Police officers, the Ministry of social protection, the County representatives from the</p>

			Departments of Health, Children's services, Gender, and Youth, directorate of public prosecution, the Faith sector, and the Civil Society
<ul style="list-style-type: none"> Support the Key Population Consortium to engage, sensitize and strengthen the capacity of county and national stakeholders on their response to key populations, human rights and the law. 	X		<ul style="list-style-type: none"> Progress on the implementation has been limited.
<ul style="list-style-type: none"> Provide periodic training to judiciary on HIV, TB, malaria and human rights, in collaboration with people living with HIV, TB and key and vulnerable populations. 	X		<ul style="list-style-type: none"> Training and sensitization of members of the judiciary does take place as noted in section 3.2.4 above.

Progress since the MTA

There has been significant overall progress on improving laws, regulations and policies relating to HIV and HIV/TB.

On 16 December 2022 the High Court delivered a landmark judgment in the sterilization without consent case referred to above, in which the High Court found that the tubal ligation of a woman living with HIV, without her consent violated her rights to dignity, freedom from discrimination, right to the highest attainable standard of health and her right to find a family and awarded damages to the claimants.

The issue of criminalization of HIV transmission, exposure and non-disclosure was also addressed by the High Court in a matter brought before it in which in December 2018 it was asked to declare section 26 of the Sexual Offences Act 3 of 2006 to be unconstitutional, void and invalid, and therefore struck from the law. This law criminalizes deliberate transmission and or exposure of life-threatening sexually transmitted diseases, including HIV. On 20 December 2022, Justice Ong'udi in the Nairobi High Court dismissed the Petition, upholding the law's constitutionality. The Petitioners intend to appeal the judgment.⁸²

"We are disappointed with both the outcome and the Court's process," said Mr Allan Maleche, the Executive Director of KELIN. "The judgment failed to consider the undisputed expert evidence. That evidence showed how this law, and its application, are not only contrary to international scientific consensus on the nature and risk of HIV transmission, but that it is also harmful to proven strategies to prevent and treat HIV effectively", he said⁸³.

⁸² In 2015 the High Court struck down section 24 of HAPCA which contained similar provisions, on the basis that it was unconstitutional.

⁸³ <https://www.kelinkenya.org/kelin-disappointed-by-high-court-judgment-in-hiv-criminalisation-case/#:~:text=24%20January%202023%20%E2%80%93%20Nairobi%20Kenya&text=It%20asked%20that%20the%20Court,sexually%20transmitted%20diseases%20including%20HIV.>

Protection of the rights of intersex children has been significantly advanced with the coming into effect of the Childrens Act 19 of 2022 in July 2022. Section 7 of the Act provides that the Principal Registrar shall take measures to ensure correct documentation and registration of intersex children at birth. In terms of section 21 “An intersex child shall have the right to be treated with dignity, and to be accorded appropriate medical treatment, special care, education, training and consideration as a special need category in social protection services”. In addition, babies identified as intersex at birth are protected against the common practice of sex assignment surgery by section 23, which provides that no person shall subject a child to organ change or removal, except with the advice of a medical geneticist.

In 2020, Kenya revised its OAT guidelines to include take-home doses and buprenorphine. Moreover, in 2022 Kenya amended its Narcotics, Drugs and Psychotropic Substances Act to decriminalize drug paraphernalia, differentiate in law between amounts for use and amounts for trafficking, reduce imprisonment for personal cannabis possession from 10 years to no more than 5 years, and introduce an option of a fine of not more than 100,000 Kenya Shillings (about USD 850) for personal cannabis possession⁸⁴. NextGen Lawyers strengthened the capacity of and supported people who use drugs to participate in and contribute to this law reform process. Whilst these amendments facilitate the scale up of harm reduction programs in Kenya, they fall short of decriminalization of drug use and possession for own use and advocacy for further amendments to the Narcotics, Drugs and Psychotropic Substances Act are ongoing.

In January 2022 the Ministry of Health commenced the process of reviewing and amending HAPCA and requested members of the public for comments and submissions to improve HAPCA. In response to this call, public interest lawyers, KELIN, the Key Populations Consortium and other NGOs and CLOs made substantive proposals to the Ministry of Health to harmonize HAPCA with provisions of the [East African Community HIV and AIDS Prevention and Management Act 2012 \(EAC HAPMA\)](#). The amendments to HAPCA are yet to be finalized.

Strategic litigation was used in 2023 to address the issue of HIV drugs and commodities stock outs. Three Petitioners brought a petition to court on an urgent basis to seek justice for violations of the fundamental rights to health and life for People Living with HIV(PLHIV) as recurrent shortages of life-saving antiretroviral medications have consistently undermined these rights.

The petition sought to compel the Ministry of Health provide treatment to the petitioners and to publicize a list of where services and support are available for persons living with HIV pending hearing and determination of the case. When the matter was heard on October 3, 2023, the Court ordered the Ministry of Health to provide the Petitioners with immediate medical treatment, including a viral load test for the mothers and an antibody test for the child⁸⁵.

⁸⁴ Republic of Kenya (2022), The Narcotics, Drugs and Psychotropic Substances (Control) (Amendment) Act, 2022. Available from http://kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/2022/TheNarcotics_DrugsandPsychotropicSubstances_Control__Amendment_Act_2022.pdf

⁸⁵ <https://www.kelinkkenya.org/landmark-case-tests-governments-commitment-to-hiv-treatment-2/>

The Chief Justice has recently tabled a Bill for the amendment of the Penal Code provisions that criminalize aspects of sex work. No copy of the Bill was available at the time of this assessment but there are concerns that the proposed amendment, whilst removing the criminal provisions, may seek to impose other sanctions or restrictions on aspects of sex work.

Gaps and Challenges

Despite the advances in improving laws, regulations and policies as outline above, there have been some setbacks and challenges:

Increased criminalization of same sex sexual relationships through the tabling of Family Protection Bill in the first quarter of 2023:

In terms of the current law in Kenya, the criminalization of same sex sexual relationships is provided for by sections 162, 163 and 165 of the Penal Code. In terms of section 162 it is an offence have "carnal knowledge of any person against the order of nature; or to "permit a male person to have carnal knowledge of him or her against the order of nature, punishable by a term of imprisonment of 14 years which can be increased to 21 years if such act is committed without consent. In terms of section 165 it is an offence for "Any male person who, whether in public or private, to commit any act of gross indecency with another male person, or to procure or attempt to procure another male person to commit any act of gross indecency with him, punishable by a term of imprisonment for five years. Section 162 is not limited in its application to men who have sex with men but may equally be applied to heterosexual oral or anal sex.

The Family Protection Bill, 2023 was prepared against the background of a series of events, which included the Supreme Court's decision in **NGO Coordination Board v Eric Gitari and 6 Others, Supreme Court Petition Number 16 of 2019** which not only held that the NGO Coordination Board was not permitted to refuse to register the National Gay and Lesbian Human Rights Commission, but further designated sexual orientation as a derivative of sex as a protected class under Article 27(4) of the Constitution of Kenya. Shortly after this decision, both the President and the former Prime Minister issued statements denouncing the Supreme Court decision and they were joined in this denunciation by numerous political and religious leaders. This condemnation and negative rhetoric have led to serious backlash on LGBTQ+ individuals, with instances of abuse, attacks and other forms of violence reported both online and offline, forcing HIV drop-in centers for MSM and TG to close and members of these populations to flee their homes and families.

The euphemistically named Family Protection Bill introduces a raft of offences, including the offence of homosexuality which attracts a sentence of not less than ten years imprisonment and the offence of capital homosexuality which attracts a death sentence. It further has provisions on aiding and abetting, conspiracy to commit homosexuality, grossly indecent acts, and expulsion of refugees. Promotion of homosexuality now attracts a fine of not less than ten million shillings, or not less than ten years imprisonment or both. The Bill further seeks to limit the nature of education that children receive in school, promote parental choice in their children's educational experiences, proscribe gender affirming care by medical practitioners, and to

specifically limited fundamental rights and freedoms of the LGBTQ+ community as provided in the Constitution of Kenya, including those that the Supreme Court of Kenya has already pronounced itself on. A number of civil society organizations are pushing back against this Bill but if the Bill is passed into law, it will have a devastating impact not only on the rights and safety and security of the LGBTI community but also on the ability to provide HIV prevention and treatment services for members of this community. The impact of this Bill on access to services not only for MSM but also for SW is illustrated by reports from one MSM led organization that provides a defined package of HIV prevention services for sex workers in Nyeri only reached just over half of the number of sex workers targeted for the period January to June 2023 due to their fear of conducting outreaches in SW hotspots due to the ongoing, often violent, anti-LGBTI campaigns.

Case Study: Legal Environment, MSM, Mombasa, HAPA Kenya, Mombasa

Despite progress in many areas over the last decades, the legal landscape surrounding LGBTIQ+ rights in Kenya remains complex. Members of the LGBTIQ+ community are still stigmatized because of their actual or perceived sexual orientation or gender identity. Following the ruling in March 2023 by the Supreme Court of Kenya affirming the rights of LGBTQ persons to register their association by the NGO Co-ordination Board, the country has witnessed a series of anti-gay protests, and particularly in the coastal region.

Amongst the various Global Fund sub-recipients affected by the anti-LGBTQ protests is HAPA Kenya, an organization that implements programs aimed at empowering the MSM/MSW community at the coast, particularly those living with HIV, in Taita Taveta, Mombasa, Kwale. Interventions include provision of care and treatment support, advocacy on human rights, legal literacy for members, access to justice service through pro bono lawyers and legal aid services. They also work to support members of the trans community in the regions they operate in.

The March protests coupled with the deteriorating safety situation saw members profiled, HAPA Kenya clinics attacked and vandalized, and confidential information relating to patients as well as other resources stolen. This necessitated evacuation of staff and closure of the HAPA Kenya clinics. Program implementation during this period was put on hold owing to security concerns as the organization monitored the situation with support from the KRCs/GF and other partners.

The support received from KRCs/GF and other partners included situation monitoring and documentation, business continuity planning, psychosocial support, relocation support to safe spaces, installation of security systems and engagement with the county leadership to ensure continuity of health services for the KP communities. HAPA Kenya also put in place daily virtual check-ins with members through the violence response platforms, reduced social media visibility, limited staff on site to handle emergencies, home based service delivery and rebranding from “MSM/MSW” to “Community”. They also engaged police from the AIDS Control Unit (ACU) to provide HIV counselling and testing services, which improved the sense of security for the beneficiaries.

Following the NSDCC/KCM Multisectoral Advocacy Engagement delegation to Taita Taveta in May, that saw engagement of both the community and county leadership, KP programming operations in the county have since resumed with a focus on integration. HAPA Kenya has re-opened its clinic in the region and security measures put in place, including the installation of alarm systems and CCTV cameras.

With the anti-LGBTQ protests still ongoing in the region backed by prominent politicians and religious leaders, HAPA Kenya with support from KRCS/GF and other partners e.g. galck+ continues to monitor the security situation and implement the various security measures put in place.

The organization, owing to the changing legal environment, is in the process developing a robust safety and security plan with support from KRCS, partners, and Technical Assistance from the Global Fund.

Limited analysis of legal environment and impact on access to services:

Unlike many other countries in the region, no Legal Environment Assessment of laws, policies and practices that impact on access to HIV has ever been undertaken in Kenya. For example, the new Childrens Act 29 of 2022 defines children as being under the age of 18. In addition, section 16 of the Act provides that provision of reproductive health services to children shall be subject to the express consent of the parent or guardian. This makes it difficult for sexually active children under the age of 18 to access reproductive health information and services, including HIV testing and treatment.

Weak mechanisms for community monitoring of and engagement in legislative processes and developments that impact communities affected by HIV and TB:

Community monitoring of and engagement in legislative processes and development that impact on communities affected by HIV and TB is piecemeal and largely limited to civil society organizations and networks in the capital. Engagement by communities in these processes at county level appears to be much more limited. There is also limited support for rapid analyses of upcoming legislation that is likely to negatively impact on the national response to HIV and TB.

Recommendations

Recommended actions include:

- Conduct a Legal Environment Assessment (LEA) on laws, policies and practices that impact on access to HIV and TB services at both national and county levels.on HIV and TB.
- Use the results of the LEA to inform targeted engagement with National and County policy makers for reforming laws and policies that impede access to HIV and TB services and exacerbate gender inequality, including those that relate to age of consent to testing and treatment and the task shift policy for HIV counselling and testing.
- Ensure both capacity and funding for conducting a rapid analysis of the impact of existing or proposed laws to provide evidence for engaging with lawmakers.
- Strengthen mechanisms for strengthen the capacity of community-led organizations and networks to effectively undertake community monitoring of and engagement in legislative processes and developments that impact on communities affected by HIV and TB.

(g) Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity

HIV program area	Score		
	Baseline (2021)	Mid-Term (2022)	Progress (2023)
Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity	2.0	2.5	3.6

As noted in the MTA, gender-based violence remained pervasive in Kenya, particularly among women living with HIV, hampering their access to comprehensive care and support. There were also staggering increases in reports of gender-based violence during the COVID-19 pandemic. The need for programming to address gender-based violence was especially pronounced at county level. As noted by one key informant in the MTA, access to the formal justice system was especially challenging for women and girls in remote communities, with victims of gender-based violence turning instead to traditional justice systems, despite the fact that sexual offences cannot be addressed via alternative dispute resolution.

The MTA noted that several rapid response initiatives had been established to support survivors of gender-based violence access services through a rapid response system, including by Healthcare Assistance Kenya (HAK). During the COVID-19 pandemic, the National Police Service, the Office of the Director of Public Prosecutions and several non-governmental organizations also established gender-based violence reporting hotlines.

In addition, several civil society organizations supported by the Global Fund, including the Centre for Rights Education and Awareness (CREAW), had trained paralegal trainers and “Stop Gender-Based Violence” champions, who in turn conducted county training of community paralegals to provide psychosocial support, mediation support and legal referrals to survivors of gender-based violence and to women concerning issues of property disinheritance, eviction and child custody. BHESP had trained sex workers, women who have sex with women, women who use drugs and bar hostesses as paralegals and peer educators, acting as local resources and the first point of contact for legal information or assistance in relation to violence, harassment and arbitrary arrest.

Supported by Aidsfonds, WOFAK had also trained women living with HIV in three counties to become ‘Human Rights Champions,’ tasked with educating others on issues including property and inheritance, stigma and discrimination and harmful cultural practices, leading discussions at chiefs’ *barazas* and support group meetings of people living with HIV and making emergency home visits to and referrals for women living with HIV who experience human rights violations. Additionally, a range of organizations, including KRCS, AYARHEP, KELIN, GVRG, NEPHAK and government entities had conducted legal literacy campaigns for women, adolescents and young people on sexual and reproductive health and rights, inheritance and property rights, and on gender-based violence. Some organizations had also engaged in training

health care workers. Afya Pwani, for example, had sensitized county health officials on HIV and reproductive health and supports female sex workers and men who have sex with men who face stigma in seeking health care services in five coastal counties (Lamu, Kilifi, Mombasa, Kwale, and Taita Taveta). While key informants interviewed during the MTA noted an improvement among health care worker focal points with respect to their response to gender-based violence and the provision of youth-friendly care, training had yet to cascade to the health facility level. Sensitization of community, religious and county leaders on gender equality was also undertaken by NACC.

Despite the creation of gender desks at police stations and the sensitization of police service members on their role in the response to SGBV and the linkages between SGBV and HIV, key informants interviewed during the MTA noted that the police remained profoundly unequipped to respond to cases of gender-based violence, and frequent transfers of police also affected the effectiveness of police sensitization and training. To strengthen the capacity of the National Police Service to prevent and respond to cases of sexual and gender-based violence, the Kenyan government announced the launch of POLICARE in August 2020, a multi-agency victim centered service for survivors of gender-based violence in one location at the county level.

In 2021 the Government of Kenya made 12 commitments, as part of Generation Equality⁸⁶, a multistakeholder initiative convened by UN Women in partnership with civil society, youth, adolescent girls, governments, the private sector and philanthropists to catalyze partners, increase investments, drive results and accelerate the full and effective implementation of the Beijing Platform for Action and the Sustainable Development Goals. These commitments aimed at ending all forms of gender-based violence and female genital mutilation (FGM) in the country by 2026 and included commitments to fully implementing legislation and policies to address gender-based violence and tracking their implementation, integrating services for gender-based violence into the essential minimum package of Universal Health Coverage, scaling up POLICARE, and establishing recovery centers and shelters in all 47 counties.

The MTA noted that although transgender persons are now included as a key population in the *Kenya AIDS Strategic Framework*, and national guidelines for the implementation of HIV/STI programs for transgender people were finalized in May 2020, there is little or no programming to address SGBV against members of the transgender community.

Significant progress has been made on the implementation of the MTA recommendations:

MTA Recommendations	Implementation status		Comments
	YES	NO	
<ul style="list-style-type: none"> Enhance strategic linkages between HIV, TB and malaria organizations and organizations and 	X		<ul style="list-style-type: none"> Progress has been made on linkages between HIV and to a lesser extent TB organizations with organizations working on GBV and

⁸⁶ <https://commitments.generationequality.org/>

institutions that work on gender-based violence and women's rights to promote a coordinated response to gender-based violence and sexual and reproductive health and to enhance gender responsiveness of human rights programming.			women's rights. This does not appear to have happened with malaria organizations.
<ul style="list-style-type: none"> Review pre-service and in-service curriculum for police regarding response to gender-based violence in collaboration with women's rights, gender-based violence and key population organizations, and revise as necessary. 		X	<ul style="list-style-type: none"> Refer to comments on this issue in section 3.2.5 above
<ul style="list-style-type: none"> Improve monitoring of cases of gender-based violence and their resolution by police and the courts, publish the results of this review, and disseminate to key Ministries, including the Ministry of Health, the Ministry of Interior and National Coordination, the Department of Justice and the Kenyan Police Service. 	X		<ul style="list-style-type: none"> Partially – although there is a tool which is used at facility level to record GBV cases and to feed this data into the KHIS, it is not clear to what extent this captures information on the resolution of these cases by the police and the courts.
<ul style="list-style-type: none"> Develop tools to assess the effectiveness of POLICARE, in collaboration with women living with HIV, women's rights, gender-based violence and key population organizations. 		X	<ul style="list-style-type: none"> This does not appear to have been done.
<ul style="list-style-type: none"> Scale up sensitization of community, religious and county leaders on HIV, TB, malaria and gender equality, in collaboration with women's rights, gender-based violence, and key population organizations. 	X		<ul style="list-style-type: none"> There has been a scale up of this intervention in the context of HIV and to some extent TB but little has been done on this in the context of malaria.

<ul style="list-style-type: none"> • Provide resources, capacity building and technical assistance for transgender leadership and advocacy. 	X		<ul style="list-style-type: none"> • The provision of resources, capacity building and TA for TG leadership and advocacy is limited.
--	---	--	---

Progress since the MTA

Significant progress to scale up programs to reduce HIV-related gender discrimination, harmful gender norms and violence against women and girls has been made since the MTA Kenya has committed to end HIV and AIDS as a public health threat and teenage pregnancies by 2030 and gender-based violence (GBV), including sexual violence, by 2026. However, the overlapping challenge of new HIV infections, adolescent pregnancies, and sexual and gender-based violence among young people, known as the “Triple Threat,” impedes progress towards achievement of the goals. To address these challenges, Government has launched the “End the Triple Threat” campaign which seeks to drive a sustained multi-sectoral collaboration, effective coordination, and resources to address underlying inequalities, including policy gaps, social, economic, legal and cultural factors which contribute to new HIV infections, teenage pregnancies and SGBV.

To date milestones achieved through this campaign include the formation of a multisectoral National Thematic Group to coordinate the implementation of the resolutions; development of the Triple Threat training manual and information handbook for use by the National Government Administrative Officers (NGAOs), community Health Volunteers (CHPs), and other Community Gatekeepers; integration of monitoring systems for tracking and reporting of the triple threat interventions, development and validation of commitment plan by ministries, departments, Agencies and Civil Societies on ending the triple threat, training of master trainers and sensitization of over 101, 000 Community Gatekeepers across 25 Counties on preventing and addressing the triple threat at the community level⁸⁷.

In the first year of implementation of its commitments made under the Generation Equality initiative Kenya has published Kenya’s Roadmap for Advancing Gender Equality and Ending All Forms of Gender Based Violence and Female Genital Mutilation by 2026⁸⁸, collected data on gender-based violence through the 2022 Kenya Demographic and Health Survey (KDHS), established an emergency toll-free line for gender-based violence assistance and general emergency responses; 54 private shelters and rescue centers now operate in 18 counties. In addition, GBV sub-indicators on implementation of laws have been submitted for inclusion in the Performance Contracts of Ministries, Departments and Agencies (MDAs) for the financial year 2022/2023.

Protection of children against harmful cultural practices has been significantly advanced with the coming into effect of the Childrens Act 19 of 2022 in July 2022. Section 23 of the Act makes it an offence for any person to subject a child to forced

⁸⁷ <https://nsdcc.go.ke/ending-new-hiv-infections-adolescent-pregnancies-and-sexual-and-gender-based-violence-the-triple-threat/>

⁸⁸ https://www.icrw.org/wp-content/uploads/2021/06/GEF_Kenya_GBV_roadmap-05.21-web.pdf

circumcision (of a male child), FGM, child marriage, virginity testing and girl child beading⁸⁹.

Additional progress on reducing HIV-related gender discrimination, harmful gender norms and gender-based violence include the following:

- An additional two Sexual and Gender Based Violence Courts were established in Siaya and Kisumu in 2023, bringing the total to three (the other being Shanzu, Mombasa).
- Multisectoral sensitization and engagement forums with key key national, county & community leaders and PLHIV, TB and KP representatives have been conducted in years 1 and 2 of GC6 implementation across 30 counties, reaching 1956 participants bringing together stakeholders to address human rights barriers to access HIV services, stigma and discrimination against key and vulnerable populations and GBV. Participants comprised Ministry of Interior- National Government Officials (Chiefs), the Gender Desk Police officers, the Ministry of Social Protection, County representatives from the Departments of Health, Children's services, Gender, and Youth, Directorate of Public Prosecution, religious leaders, and civil society organizations (NSDCC).
- A standardized information package has been developed for use by community gatekeepers and other opinion leaders in addressing social cultural norms that fuel GBV, teenage pregnancy, and new HIV infections during community dialogues (NSDCC).
- Community gatekeepers (Chiefs, Women Opinion leaders, CHPs) have been sensitized on preventing and addressing social cultural norms that fuel gender-based violence and HIV related gender inequalities in 22 Counties (NSDCC).
- One-day biannual sensitization meetings with law enforcers and key GBV stakeholders have been conducted in ten counties (Kilifi, Kajiado, Narok, Baringo, Laikipia and Samburu, Nairobi, Kakamega, Mombasa and Kisumu) with 747 participants drawn from the National Police Service, Childrens Department, Ministries of Interior and Education, religious leaders, GBV survivors, partners, and the Department of Public Prosecutions. The purpose of these meetings was to provide a platform to sensitize law enforcers on HIV/ GBV and human rights violations in their respective Counties and to strengthen coordination among actors in the criminal justice system, medical and community services to adequately handle sexual and gender-based violence and HIV related cases (NSDCC).
- Multisectoral County and Constituency Human Rights and Gender Coordinating Committees have been established in 15 priority counties have been established and meet quarterly to enhance prevention, reporting, and referral of HIV/TB & Malaria related human rights violation including GBV, stigma and discrimination (NSDCC).
- Makueni County has established five Multisectoral Sub-County and Constituency Human rights and Gender Coordinating Committees (in Kathozweni, Kibwezi, Mbooni East, Mbooni West and Kaiti) utilizing GoK funds.

⁸⁹ The offence attracts on conviction a term of imprisonment of not less than 3 years or fine of not less than five hundred thousand shillings, or to both. Where the death of a child results, the sentence on conviction is life imprisonment.

- Health care workers have been trained on the collection of forensic evidence in sexual and gender-based violence cases (NASCOP).
- KRCS and its SRs have integrated information on GBV and on where to seek assistance into structured dialogue sessions that they conduct with women living with HIV on sexual and reproductive health and NCDs.
- They have also incorporated information on GBV and where to seek assistance into sensitization meetings conducted at the sub-county level in collaboration with the Department of Social Welfare with parents and guardians, chiefs and assistant chiefs, village elders and community GBV committees on the Return to School policy for Pregnant AGYW.
- KRCS has also developed an online referral directory of both social and legal services, with a view to improving access to both. The online directory is easy to navigate and features drop down menus in respect of the geographic area and the type of services that are being sought⁹⁰. It is also available as a mobile app.⁹¹ The legal support services listed in the online directory include the provision of legal information, as well as links to legal, psychosocial and other support and pro bono services including legal counselling, litigation and legal representation. These include:
 - GBV prevention and responses initiatives.
 - Integrated services for SGBV survivors
 - Support for GBV survivors, psychosocial Support
 - Linkage to safe house and, temporary shelters for GBV survivors.
 - Rehabilitation of non-custodial offenders.
 - Harm reduction referrals.
 - Collection of specimens for screening for GBV.
 - Alternative Community dispute and conflict resolution.
 - Support for legal aid and litigation
- A GBV reporting tool has been developed for use at facility level. The data collected at facility level is loaded into a monthly summary tool, which is uploaded to the Kenya Health Information System.

Gaps and challenges

- Despite a drop in the percentage of women who experienced physical violence in the 12 months before the survey from 20% in 2014 to 16% in 2022, the rates of physical and sexual violence against women age 15-49 remain fairly high with significant variations by county. By county, the percentage of women who have experienced physical violence since age 15 is highest in Bungoma (62%) and lowest in Mandera (9%). The most commonly reported perpetrator of physical violence among women who have ever been married or ever had an intimate partner was their current husband or intimate partner (54%), followed by a former husband/intimate partner (34%). Thirteen percent of women reported that they had experienced sexual violence at some point in their lives, and 7% reported that they had experienced sexual violence in the last 12 months. Similar to physical violence, percentages of women who have experienced sexual violence are highest in Bungoma (30%).⁹²

⁹⁰ https://referraldirectories.redcross.or.ke/?page_id=1625

⁹¹ https://files.appsgeyser.com/Red%20Cross%20Referral%20Directories_17204657.apk

⁹² Kenya Demographic Health Survey 2022

- Despite Government's commitment under the Generation Equality Initiative to scaling up POLICARE, and establishing recovery centers and shelters in all 47 counties, as of June 2023 only one operational POLICARE facility had been established in Nanyuki.⁹³
- An HIV Community Rights and Gender Assessment yet to be conducted (although this is planned to take place before the end of 2023).
- Despite progress in the interventions undertaken to improved co-ordination of and linkages between GBV programs, there is still a need for improved coordination, linkages, referrals and monitoring of GBV cases.
- The GBV reporting tool needs to be digitalized to inform programming and monitor 100% linkage to services for GBV survivors and resolution of cases.
- Despite the passing into law of the new Childrens Act, 2022 and interventions to sensitize community gatekeepers and opinion leaders on harmful social cultural practices that increase vulnerability to HIV, TB, SGBV, new HIV infections and adolescent pregnancies.
- There is insufficient access to psychosocial and legal support for GBV survivors.
- Whilst the transgender community report fairly high levels of GBV⁹⁴, interventions to address GBV against transgender people are lacking.

Recommendations

Progress in programming for gender inequality, reducing harmful gender norms and addressing GBV has benefitted from broader, integrated programs to increase legal literacy and access to legal support services, as well as efforts to sensitize law enforcers. However, critical and specific gendered issues facing people living with HIV, people with TB and key populations remain less well understood and addressed. In addition to continuing existing work, it is recommended that the following actions be taken:

- Strengthen strategic linkages between and accountability of all actors to promote a coordinated response to HIV/GBV/SRH through implementation of the Inter-ministerial commitment plan on ending new HIV infections, GBV and gender inequalities.
- Scale up POLICARE facilities and establish safe houses and shelters in all 47 counties that are KP friendly.
- Scale up interventions to address GBV against transgender people.
- Strengthen County Gender, HIV, GBV and Human Rights Coordinating Committees for improved coordination, referrals and monitoring of GBV cases.
- Undertake the validation and digitalization of the GBV reporting tool and use the data to inform programming and monitor 100% linkage to services for GBV survivors and resolution of cases.
- Conduct needs assessment of Gender Desks and Child Protection Units and use the results to strengthen both.

⁹³ <https://nation.africa/kenya/news/gender/was-the-state-really-ready-for-policare--4288602>

⁹⁴ A Report Of The National Transgender Discrimination Survey In Kenya (NTDS) 2020: <https://static1.squarespace.com/static/5a1d2df4f6576eb8bfad8b0e/t/62827974b2c7e70d4d848962/1652718075824/NTDS+Report+Policy+Brief.pdf>

- Strengthen the capacity of community gatekeepers and opinion leaders to address and raise awareness about harmful social cultural practices that increase vulnerability to HIV, TB, SGBV, new HIV infections and adolescent pregnancies.
- Review the male engagement toolkit to integrate human rights and gender transformative approaches.
- Conduct sensitization of national, county and community HIV and TB actors on the national GBV guidelines.
- Develop, produce, and distribute behavior change communication materials on SGBV.
- Strengthen linkages between community based and led organizations to strengthen GBV response.
- Recruit, capacity build and support GBV champions and paralegals to provide survivor centred support for GBV survivors.

(h) Community mobilization & advocacy for HIV and TB

HIV program area	Score		
	Baseline (2021)	Mid-Term (2022)	Progress (2023)
Community mobilization and advocacy for HIV and TB	*	*	3.0

Progress

The funding provided by the Global Fund under GC6 for community mobilization and advocacy for HIV and TB, which are critical to ensuring a rights-based response to HIV and TB, is held by AMREF. Interventions to make progress on community mobilization and advocacy for HIV and TB to date include the following:

Institutional capacity building, planning and leadership development

- Building capacity of Networks and CSOs through Organizational Development and Systems Strengthening (ODSS): Under the GC5 and GC6 grants, a total of 598 organizations and networks received ODSS and as at June 2023 1,325 organizations including networks had been reached with mentorship. In addition, 60 AYP led organizations received ODSS and mentoring were also trained and 60 mentored. AMREF is currently working on a graduation plan that will ensure that organizations that have improved are graduated from the ODSS program.

Social mobilization, building community linkages and coordination

- Training and support for 30 social mobilization champions per county in all the 47 counties: Under GC6 1,325 social mobilization champions were trained. As of June 2023, 1,029 champions were active and receiving a monthly stipend. The champions are conducting activities including awareness creation of HIV, TB and malaria and community led monitoring. They also work together with CHPs during health dialogue and action days and link the communities with the health facility boards community representatives to ensure issues raised by communities are addressed by the health facilities.

- Supporting community actors to participate in national health days (World TB, Malaria and HIV/AIDs days) by organizing and mobilizing participants from different areas/networks as well as supporting the distribution of IEC and BCC materials in 15 counties: Various CSOs/network representatives in each of the 15 counties were facilitated to participate in national health days (World TB, Malaria and HIV/AIDs days) activities at and distribute various IEC and SBCC materials annually.

Community-led advocacy and research

Under GC6 AMREF put out a call for applications for grants for community led and based organizations, networks and civil society actors, particularly those representing marginalized, under-served and key and vulnerable populations for community led research. Out of the 72 applications received, 24 were awarded grants and the research is ongoing.

AMREF also conducted training for 300 Domestic resource mobilization (DRM) Champions who participate in the development of County Development Improvement Plans, as well as in public participation processes for budget monitoring and approval of bills. They also engage in advocacy for the uptake of the National Health Insurance Fund (NHIF).

AMREF also trained 150 citizen advocates who conduct advocacy in collaboration with other community actors based on data gathered through Community Led Monitoring.

Community Led Monitoring

AMREF supports community led monitoring by service users and/or local communities who gather, analyze and use information collected by way of an app “Imonitor ATM+” on an ongoing basis to improve access to, quality and impact of services, and to hold service providers and decision makers accountable. Under GC6 AMREF has upgraded the Imonitor ATM+ tool to enable it to uptake data relating to human rights violations in terms of access to services. AMREF has also trained 33 community actors and GoK staff as Trainers of Trainers on the use of the Imonitor ATM+ tool and by June 2023 had supported the training of 409 peer monitors to use the Imonitor ATM+ tool for CLM in 15 countries. As at June 2023, 12081 issues with access to services were reported through Imonitor.

Gaps and challenges

- Despite investments by AMREF, community leadership and engagement in public participation and legislative processes for law and policy reforms relating to TB and HIV requires additional support and strengthening.
- There is insufficient support in terms of funding and capacity strengthening of community led organizations to engage in community mobilization and advocacy.

Recommendations

- Strengthen community leadership and engagement in public participation and legislative processes for law and policy reforms relating to TB and HIV.

- Develop and implement a community led advocacy strategy and plan.
- Ensure that funding gets down to community led organizations to engage in community mobilization and advocacy.
- Provide targeted capacity-building initiatives for community-led organizations, focusing on areas such as project management, advocacy strategies, financial management, and organizational development. Strengthening their capacity will enhance their ability to engage in effective community mobilization and advocacy.
- Continue and expand support for community-led research and advocacy initiatives. This empowers communities to generate evidence, participate in policy dialogues, and advocate for changes that positively impact their health and well-being.

3.2 Progress to remove barriers to TB services

While there have been efforts to expand programs, there continues to be a limited number of programs in Kenya to remove human rights- and gender-related barriers to TB services.

The *National Strategic Plan for Tuberculosis, Leprosy and Lung Health 2019-2023* proposes the following interventions to ensure a human rights and gender-based approach to TB management and care:

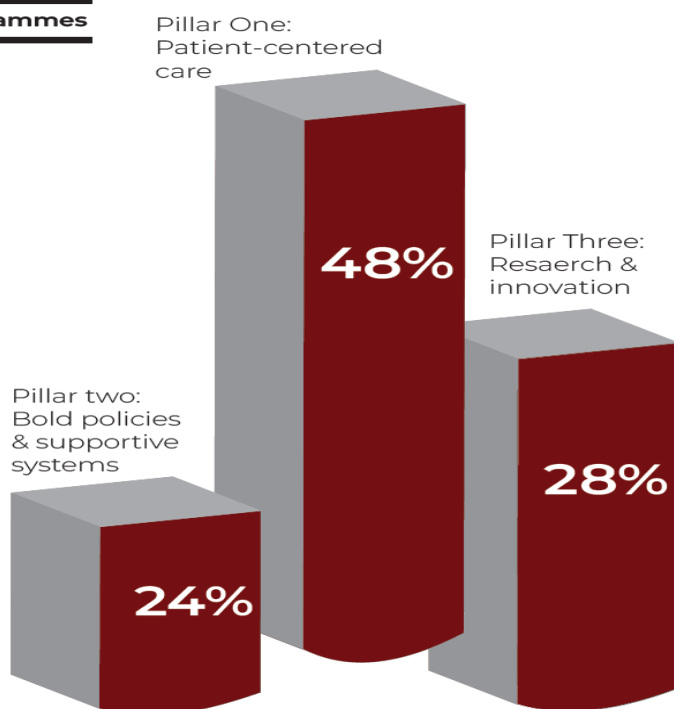
- Sensitization of lawmakers, law enforcement agents and HCW on a rights-based approach in the management, treatment, care, and support of TB patients.
- Removal of the legal, human rights and gender barriers to access of TB, leprosy and lung diseases services.
- Monitoring and reforming laws, regulations and policies relating to TB, leprosy lung diseases.
- Formation of intersectoral partnerships between the Ministry of Health (DNTLD-P) and other departments within government to embed TB, leprosy and lung diseases concerns⁹⁵.

A 2022 CSOs mapping exercise undertaken by KeNAAM, tasked by AMREF with support from the GF to generate a database of civil society organizations involved in malaria, HIV, TB, and other related health programs in all 47 counties showed that of the CSOs working on TB, only 24% were working on structural barriers to access to TB services and of these 20% were working on human rights and gender and only 3% were engaged in advocacy.⁹⁶

⁹⁵ *National Strategic Plan for Tuberculosis, Leprosy and Lung Health 2019-2023*

⁹⁶ MAPPING OF KENYA CIVIL SOCIETY ORGANIZATIONS WORKING IN SECTOR REPORT MALARIA, HIV & TB, Kenaam 2022

TB Programmes



The *Report of the End-Term Review of the National Tuberculosis, Leprosy and Lung Health Strategic Plan, 2019-2023* noted significant efforts towards the strategic interventions. These include establishing partnerships between DNTLD-P, Networks of TB-affected communities and civil society, which provide a channel for accountability and collaboration, capacity building of TB champions in 10 counties on human rights and gender (HRG).

End-Term Review key findings, progress and achievements

The National TB Program has done initial assessments of the legal, policy, and gender gaps related to TB and Key populations. Though not to scale, these initial assessments informed the various chapters of the current TB strategy and the previous one. Incorporating human rights and gender in the National Strategic Plan as well as the development of an isolation policy have been documented as milestones.

There are established partnerships between the National TB Program, Networks of TB affected communities and civil society. This has provided a good channel for accountability and collaboration. Media & educational campaigns done through Global Fund funding, CFCS grant on matters human rights and gender in partnership with the National TB program. In addition, there have been GF-funded media and educational campaigns and an active national network of people affected by TB and CSOs. Program data is also segregated by age and gender, and there is a focal person focusing on HRG issues at DNTLD-P. The support for the Stop TB Challenge Facility has helped move forward some of the recommendations, including setting up an active National network of TB champions.

End-Term Review main challenges and areas requiring improvement

The End-Term Review identified the following gaps and challenges:

- The absence of a costed operational framework for gender and human rights activities has slowed down the pace of implementation as well as made it difficult to assess the progress made.
- Many county TB coordinators did not have strategic plans that addressed human rights and gender issues, with many using World TB day as their only avenue of reaching out to the public on matters of TB, human rights, and gender.
- General lack of knowledge on HRG at all levels of implementation. In addition implementers have different view levels of understanding regarding HRG and existing legal framework/laws that can be used as tools to champion HRG issues. Many implementers have limited understanding of how to integrate HRG into TB programming.
- Minimal measurement, monitoring or remedies of and for TB stigma and discrimination.
- Delays in accessing social protection packages (NHIF, monthly allowances) which are only available for DR TB clients excluding DSTB and Post TB clients.
- TB services have not factored in People Living with Disability, especially those with hearing impairment.
- Prison set up do not have isolation facilities and if they have they do not meet the minimum required standards as set out in the Isolation policy.
- 43 counties do not have isolation centers as envisioned by the TB Isolation Policy, with those with isolation facilities not meeting the minimum required standards as set out in the Isolation policy.
- Majority of facilities lacked a visibly displayed TB patient charter and those with, it is not translated into local language and made to be age appropriate and disability friendly.

Key recommendations of the End-Term Review

- Strengthen coordination and structures for TB related human rights reporting at the national and county levels.
- Development of a costed community rights and gender operational plan at national and county levels.
- Development of an M&E framework for HRG, with set output targets and indicators for HRG and social protection activities to systematically implement and monitor the strategic interventions in the NSP.
- Need for technical support from UN agencies and development partners on TB HRG issues particularly in operationalization of policies and assessments.
- Funding TB HRG interventions and enhance Community led monitoring interventions of service quality and to enhance peer support and community mobilization.
- Improve multi-sectoral collaboration and accountability between the National TB program, TB Actors and other sectors at the National and County levels.
- Need for tailored services and programming for key and vulnerable populations depending on county context.
- Sensitization of all stakeholders at all levels on TB equity, ethics and HRG issues pertinent to their sector, including public awareness on their rights and responsibilities including in terms of the Patient Charter.

- Engage technical support from UN agencies and development partners on TB HRG issues particularly in operationalization of policies and assessments.
- Need to operationalize policies launched at the National level, including the TB Isolation policy and ensure social support for MDR TB patients is availed to all.

(a) Eliminate TB-related stigma and discrimination

TB program area	Score		
	Baseline (2021)	Mid-Term (2022)	Progress (2023)
Eliminating TB-related stigma and discrimination	3.0	3.0	3.6

As noted in the MTA, TB stigma remains high in Kenya, driven in part by an association of TB with HIV, and manifests in patient isolation, fear of disclosing TB diagnosis, and lack of social support. According to key informants interviewed during the MTA, stigma related to COVID-19 exacerbated TB stigma during the pandemic and affected TB programming.

During the mid-term assessment, several organizations were reported to be implementing programs to address TB-related stigma and discrimination, though these are limited in geographic scope. In 2021, KELIN trained “TB champions” in Nairobi, who shared their personal experiences with TB in the media (Switch TV and NTV) to sensitize the public. The NGO Talaku worked in Kajiado county promoting public awareness of TB through community health volunteers and outreach activities during market days and community awareness activities. As noted at baseline, in Busia and Mombasa counties, WOFAK had developed and distributed educational resources and conducted quarterly community sensitization dialogues and TB advocacy sessions, with a focus on people living with HIV, health care workers, mobile populations, prisoners and contacts of TB patients. The Stop TB Partnership Kenya was also active on social media, tackling myths related to TB transmission and sharing health promotion messages via various TB ambassadors⁹⁷.

Progress on the implementation of the MTA recommendations has been good:

MTA Recommendations	Implementation status		Comments
	YES	NO	
i) Conduct TB stigma assessment in line with Stop TB Partnership tool, disseminate findings to relevant Ministries including the Ministries of Health, Labor, and Interior and the National Prison Service, and develop a TB Stigma	X		<ul style="list-style-type: none"> Partially – data collection is underway and it is anticipated that the report will be finalized before the end of the GC6 grant period.

⁹⁷ MTA Report p44,45

reduction plan that includes an advocacy, communications, and mass media plan.			
j) In consultation with people living with TB, develop and disseminate a TB workplace policy to address issues of TB screening and non-discrimination of employees with TB and target dissemination of the policy to the formal and informal sector, including employers and workers in the mining sector, fishing industry, transportation sector and industrial/factory sector.	X		<ul style="list-style-type: none"> The TB workplace policy has been developed and disseminated.
k) Sensitize stakeholders including justice, labor, housing, social protection, health care workers on TB-related human rights concerns, including via the dissemination of the TB Legal Environment Assessment and the TB Gender Assessment.	X		<ul style="list-style-type: none"> Partially: sensitization and awareness raising has focused primarily on the education, workplace and transport sectors.
<ul style="list-style-type: none"> Strengthen the capacity of the national network of people affected by TB to establish regional chapters of the network to address TB-related stigma and other rights violations faced by people living with TB. 	X		<ul style="list-style-type: none"> Yes – see section 3.3.6 for further detail.

Progress since the MTA

Good progress has been made on programming to reduce TB-related stigma and discrimination since the MTA.

The National TB Program, Leprosy and Lung Disease Program (NTLP) has collaborated with KRCS, NASCOP and NSDCC to integrate TB into existing HIV-related stigma and discrimination reduction programs. The NTLP places a specific focus on stigma and discrimination reduction in the education sector and in the employment sector where levels of TB-related stigma and discrimination are relatively high. Senior boarding schools carry a high burden of TB as Kenya has a policy of

100% transition from primary to secondary education but the amount of accommodation available in senior boarding schools has not increased to accommodate the increased number of senior school students, which results in overcrowding. Students diagnosed with TB are sent home. The NTLP has been working with heads of schools, teachers, counsellors and matrons across Kenya to raise awareness about TB and the need for sufficient accommodation and adequate ventilation.

In the employment sector, NTLP works with the Federation of Kenya Employers (FKE) and the trade unions to create awareness about TB and to reduce TB-related stigma and discrimination in the workplace. FKE implements programs to build the capacity of employers to implement wellness programs that support employees being treated for TB (or any other condition) by providing sick leave, medical coverage and a non-discriminatory environment. The Public Sector HIV Policy has been updated to include TB and is now a combined HIV/TB workplace policy. In addition, a Workplace Policy on Tuberculosis Disease Management was developed jointly by the Division of National, Tuberculosis Leprosy and Lung Disease-Program (DNTLD-P) of the Ministry of Health in conjunction with the Ministry of Labor, International Labor Organization (ILO), Kenya Federation of Jua Kali Association, Federation of Kenya Employers (FKE), Central Organization of Trade Unions (COTU(K), Kenya Health Federation (KHF) and the Kenya Private Sector Alliance (KEPSA) and was adopted in 2022. One of the stated policy objectives is to eliminate TB-related stigma and discrimination at the workplace.

In communities, TB Champions create awareness and advocate for stigma and discrimination reduction at community level in public meetings/barazas/community dialogues and through know your rights campaigns.

NLTB uses World TB Day to conduct a stigma and discrimination reduction campaign using social media and human-interest stories that have sparked a lot of debate about TB-related stigma and discrimination on social media. In addition, the innovation challenge fund that was provided for in GC6 was utilized to conduct a successful campaign to provide information on TB and related stigma and discrimination targeting the transport sector through community radio reaching a larger number of truck drivers.

Gaps and Challenges

Despite progress in programming to eliminate TB-related stigma and discrimination, key informants interviewed for this assessment indicated that levels of TB-related stigma and discrimination in communities remains high. One key informant remarked as follows: *“People easily say “When I had COVID...” but you never hear people saying “When I had TB...” You will also never hear TB being mentioned in a eulogy.”*⁹⁸ Several key informants interviewed in the course of this assessment referred to the fact that the integration of TB into existing HIV stigma reduction programs can be

⁹⁸ Key informant interview with Stop TB representative 30 May 2023.

challenging as the HIV component often overshadows the TB component. In addition, the drivers of TB and HIV-related stigma and discrimination are different.

While 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, programs to address TB-related stigma and discrimination are far from reaching national-level coverage, tend to focus more, and reach more people affected by HIV than TB and fail to adequately monitor and evaluate the impact on access to treatment, care and support. In addition, the TB Stigma assessment, which will provide vital information to guide TB-related stigma and discrimination reduction programming, has yet to be completed.

Additional challenges, which are faced not only in stigma and discrimination elimination programming but in all TB human rights and gender programming include the following⁹⁹:

- The absence of a costed operational framework for gender and human rights activities has slowed down the pace of implementation as well as made it difficult to assess the progress made.
- Many county TB coordinators did not have strategic plans that addressed human rights and gender issues, with many using World TB day as their only avenue of reaching out to the public on matters of TB, human rights, and gender.
- General lack of knowledge on the part of TB program staff on HRG at all levels of implementation.

Recommendations

- Ensure that new National Strategic Plan for Tuberculosis, Leprosy and Lung Health, which is currently under development, highlights the implementation of programs to reduce stigma and discrimination related to TB, including internalized stigma, as a strategic intervention to remove legal, gender, and human rights barriers to TB services.
- Disseminate and implement the TB workplace policy.
- Provide technical support to CSOs and CLOs to develop and implement TB workplace policies in their own organizations.
- Finalize the TB stigma assessment and use the findings to develop a TB stigma reduction plan.
- Develop and implement a communication plan on TB stigma, its impact, and available services.
- Conduct awareness and advocacy campaigns for TB stigma reduction in communities, prisons, humanitarian settings, police holding cells, and workplaces.
- Develop and implement an improved M&E system that looks at the impact as well as outputs of stigma and discrimination reduction interventions.
- Strengthen coordination and structures for TB related human rights reporting at the national and county levels.
- Develop and implement a costed community rights and gender operational plan at national and county levels.

⁹⁹ *ibid*

- Ensure the meaningful participation of KP in the design and implementation of stigma and discrimination reduction programs.
- Request technical support from UN agencies and development partners on TB HRG issues particularly in operationalization of policies and assessments.

(b) Ensuring people-centered and rights-based TB services at health facilities

TB program area	Score		
	Baseline (2021)	Mid-Term (2022)	Progress (2023)
Ensuring people-centered and rights-based TB services at health facilities	1.0	2.0	2.3

As noted in the MTA¹⁰⁰, TB stigma in health care settings is reportedly high; a study of TB patients in rural West Pokot county revealed poor treatment by health care workers, with higher rates of experienced and perceived stigma among women. As a 2020 desk-based assessment of health care worker knowledge of human rights, medical ethics, HIV, TB, privacy and confidentiality revealed, workers have minimal knowledge of human rights and the law and what actions constitute human rights violations.

At the time of the MTA training of health care workers on human rights and medical ethics relating to HIV had increasingly included concerns related to TB. In addition, training on TB-specific human rights of health care workers, community health advocates and community health volunteers had been provided by KELIN, AMREF, Stop TB, Pamoja TB Group, NTLP, NASCOP and others in Meru, Mombasa, Nairobi, Kisumu, Homa Bay, Kajiado, Busia and Migori counties.

Support from the National Treasury also facilitated the dissemination to public health officers across Kenya of the 2018 *Tuberculosis Isolation Policy*. There is no indication, however, of evaluation of these efforts' impacts.

Progress on the implementation of the MTA recommendations has been limited, largely due to the fact that the TB and human rights training module has yet to be finalized and integrated into pre-service training for health care workers:

MTA Recommendations	Implementation status		Comments
	YES	NO	
l) Develop TB and human rights training modules for preservice medical training of all health care workers and build capacity of health care training institution personnel to deliver the preservice human rights		X	<ul style="list-style-type: none"> Despite being budgeted for in GC6, the module has not been finalized, nor has it been integrated into pre-service training for health care workers.

¹⁰⁰ MTA Report p45

curriculum, including via collaboration with people living with TB and key and vulnerable population organizations.			
m) Standardize and scale up training of TB community health advocates on human rights, TB and recourse for rights violations, and link community health advocates with local paralegals to facilitate access to justice.	X		<ul style="list-style-type: none"> Progress on the implementation of this recommendation has been minimal.

Progress since the MTA

As noted in section 3.1.2 above, NASCOP intended to integrate all human rights-related HIV and TB content into one module and integrate this into the pre-service curricula at all health care worker training institutions. Despite this activity having been budgeted for under GC6 it appears that the training manual has yet to be finalized and that funds allocated for the finalization of the manual and the integration of the module into pre-service training has been reprogrammed for in-service training of health care workers. In the absence of a finalized training manual, it appears that outdated existing materials are being used to undertake the in-service training.

In the absence of pre-service training of health care workers, NASCOP and NTLP have carried out in-service training of health care workers on HIV, TB, law, human rights and ethics in the context of health care.

As was the case in the MTA, key informants interviewed in this assessment again highlighted the need to train more community health volunteers, who are ideally situated to provide information about HIV, TB and human rights and to provide support services and to finalize and integrate the module on HIV, TB and human rights into all health care worker pre-service training.

One key informant interviewed for this assessment noted that *“We train lawyers (on how to assist people with TB whose rights have been violated) and wait for things to blow up – we should be more proactive and train HCW not to discriminate.”*¹⁰¹

Gaps and challenges

Despite being budgeted under GC6, NASCOP has yet to finalize the consolidation of the human rights-related HIV and TB content into one module and integrate this into pre-service training. In-service training is conducted by NASCOP and NTLP as well as by various civil society organizations, but the in-service training is largely ad hoc,

¹⁰¹ Key informant interview with Stop TB representative 30 May 2023.

with no overall coordination. The scale up of in-service training of health workers continues to be modest, and insufficiently evaluated; this program area has not yet addressed a number of the challenges and recommendations cited in the MTA.

Another fundamental challenge is the fact that 43 counties do not have isolation centers as envisioned by the TB Isolation Policy, and where they are in place, they do not meet the minimum required standards as set out in the TB Isolation policy. In addition, the majority of health care facilities do not display the TB patient charter and where it is displayed it has not been into the local language or been made age appropriate or accessible by people with disabilities.¹⁰² Linkages between private health facilities and established community structures creates a challenge in fighting stigma and discrimination in private health facilities where most clients would want to keep their issues private and may not want to disclose stigma related violations or agree to disclose household information/decline visitation by community actors, even for contact tracing. This has resulted to treatment interruption or loss to follow up at times.

Recommendations

The Assessment recommends the following:

- Finalize and integrate TB, HIV and human rights training modules in the pre-service training for all health care workers and build capacity of health care training institution personnel to deliver the pre-service human rights curriculum, including via collaboration with people living with HIV and key population organizations.
- Institutionalize regular, in-service refresher training for all health facility staff on HIV, TB, human rights, gender equality (including training related to GBV and SRH) and medical ethics, including on the Kenya National Patients' Rights Charter.
- Produce and implement standardized training curriculum for community health volunteers on HIV, TB, human rights, gender equality (including training related to GBV and SRH and medical ethics and support ongoing training for community health volunteers.
- Strengthen linkages between private health facilities and established community structures to facilitate stigma and discrimination reduction in private health facilities.
- Support implementation of an M&E system to document not only the coverage but also the impact of human rights related training on health outcomes, disaggregated based on sex, gender identity and sexual orientation.

(c) Ensure rights-based law enforcement practices for TB

TB program area	Score		
	Baseline (2021)	Mid-Term (2022)	Progress (2023)
Ensuring rights-based law enforcement practices for TB	1.0	1.5	2.0

¹⁰² Republic of Kenya, Ministry of Health, Report of the End-Term Review of the National Tuberculosis, Leprosy and Lung Health Strategic Plan, 2019-2023, 2022 at p60

As noted in the MTA, from 2016 to 2019, KELIN hosted an annual Regional Capacity Building Forum on “HIV, TB, Human Rights and the Law” for law enforcement officers and health care workers to share personal and professional experiences on removing legal barriers that prevent key populations from accessing services. NACC (now NSDCC), in conjunction with HIV and TB partners, also carried out activities to train 382 prison personnel on the linkages between public health, human rights and HIV and TB responses. However, little additional programming had been reported on this front and the MTA found that there was insufficient integration of TB in efforts to sensitize law enforcement officials regarding HIV.

Progress to implement the MTA recommendations has been limited:

MTA Recommendations	Implementation status		Comments
	YES	NO	
<ul style="list-style-type: none"> Support civil society and key population led organizations to continue and scale up community led monitoring of human rights violations, including violations perpetrated by law enforcement, and incorporate findings into efforts to sensitize law enforcement and for advocacy purposes. 	X		<ul style="list-style-type: none"> Various KP led organizations are monitoring human rights violations at the hands of law enforcement and are engaged in sensitization of Kenya National Police Service members.
<ul style="list-style-type: none"> Finalize curriculum for preservice training of police on HIV, TB, key populations, gender equality and human rights in collaboration with people living with HIV, TB, gender equality and key population organizations and incorporate training into National Police Service Training Curricula. 		X	<ul style="list-style-type: none"> This has yet to be finalized and incorporated into pre-service training.
<ul style="list-style-type: none"> Build capacity of police and prison service training facilitators to deliver the HIV, TB, key populations, gender equality and human rights training, including in consultation with people living with HIV, TB, gender equality and key population organizations. 	X		<ul style="list-style-type: none"> This has been undertaken, albeit on a relatively small scale as a result of failure to finalize and incorporate the HIV, TB human rights, gender and law module in pre-service training.

<ul style="list-style-type: none"> • Conduct knowledge and attitude assessments of police and prison services on rights of people living with HIV, TB and malaria and key and vulnerable populations to help determine priorities for ongoing in service training. 	X		<ul style="list-style-type: none"> • A knowledge assessment will be undertaken before the end of the GC6 funding period.
<ul style="list-style-type: none"> • Support civil society and key population led organizations to continue and scale up engagement and sensitization of lawmakers at county and national level on HIV, TB, malaria, key populations, gender equality and human rights. 	X		<ul style="list-style-type: none"> • Civil society and key population led organizations do engage with lawmakers, albeit on a relatively small scale (see section 3.6 below).
<ul style="list-style-type: none"> • Develop monitoring and evaluation tools to routinely assess effectiveness of and impact of law enforcement and lawmaker sensitization efforts, disaggregated based on sex, gender identity and sexual orientation, and adjust these efforts as necessary. 		X	<ul style="list-style-type: none"> • Monitoring and evaluation tools have not been developed and there is an urgent need to do so.

Progress since the MTA

As is the case with HIV, whilst this assessment did identify several interventions which had been implemented since the MTA, overall progress on ensuring rights-based law enforcement practices in the context of TB has been limited.

NSDCC hosted two meetings with a view to building the capacity of police service training facilitators to deliver in service training on HIV, TB and human rights as well as on human rights and gender related barriers to access to HIV and TB services and on GBV/SGBV. The first was attended by 10 participants from the Kenya Prisons Service as well as by representatives from NSDCC, NASCOP and the TB program to discuss barriers to access to HIV and TB services that are particular to the prisons setting. At the second meeting, 24 participants drawn from inmates, prison service staff and their families in eight regions were trained as trainers of peer trainers who will cascade the training down at the participating prisons.

An HIV, TB, human rights and law training module for incorporation in police pre-service training has been developed by NASCOP but to date only pilot training has been conducted using this module in order to test the module with limited participants and the module has yet to be incorporated into the police pre-service training curriculum as it has not been approved by police service senior management. Thus, training of police service members is still limited to in-service sensitization, conducted primarily by key population led organizations including BHESP (SW), Men Engage (GBV), Jinsiangu (TG) and Reach Out Trust (PWID) at individual police station level.

A key informant from NSDCC interviewed in the course of this assessment indicated that the current plan is to develop one standardized module on HIV, TB and human rights for integration into the existing curriculum for pre-service training of both the national police and prison services.

To this end two meetings were held with participants drawn from the Police Training College, the Police Headquarters AIDS Control Unit, NASCOP, NSDCC, the TB Program and communities to review the module and to train 26 National Police Service Instructors and Department Heads from the National Police Training College (Kiganjo).

It appeared at the time of this assessment that despite this initiative the standardized module has yet to be incorporated into the Police Service and Prisons Service Pre-service Training curricula and several key informants interviewed during the course of this assessment indicated that developing and implementing a standardized module for incorporation in pre-service training for both the Police Service and the Prisons Service is not a good option as the contexts in which members of the Police Service and the Prisons Service operate are completely different.

Gaps and Challenges

- The training module developed by NASCOP for incorporation in both the Police Service and Prisons Service pre-service training curricula are yet to be approved by Senior Management of the Police and Prisons Services respectively and are thus currently not included in the pre-service training.
- Training of both Police and Prisons Services members is limited to in-service training at individual facility level due to lack of buy-in by senior management of both Services.
- Neither the impact of, nor the coverage of the in-service training efforts is well evaluated, with anecdotal reports serving as evidence of impact.

Recommendations

There continues to be some limited progress in the training and sensitization of law enforcers. However, the Global Fund support to integrate training within pre-service training of the National Police Service and the Prisons Service continues to have limited success, and various challenges remain. In addition, the impact of the in-service training efforts is not well evaluated, with anecdotal reports serving as evidence of impact across various sectors.

To achieve comprehensive programs to ensure rights-based law enforcement practices, the following steps are recommended:

- Develop monitoring and evaluation tools to routinely assess not only the reach and coverage of but also the effectiveness and impact of training disaggregated by sex, gender identity and sexual orientation, and adjust these efforts as necessary.
- Scale up engagement with stakeholders in law enforcement to strengthen their understanding of HIV, TB, key populations, human rights and gender.
- Support community led dialogues with sub county security, NGAOs and Nyumba Kumi¹⁰³ to strengthen community- security structures relations.
- Review and update the Police Service human rights training module to reflect results from the TB stigma assessment (once it is completed) and knowledge and attitude assessments conducted under GC6.
- Develop a human rights training module for the Prisons Service and integrate this module into pre-service training.

(d) Improving TB-related Legal literacy ("know your rights")

TB program area	Score		
	Baseline (2021)	Mid-Term (2022)	Progress (2023)
Improving TB-related legal literacy ("know your rights")	*	1.5	2.0

As noted in the MTA¹⁰⁴, small-scale work had 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 and vulnerable populations that has included content on TB. At the time of the MTA, KELIN had worked with local partners to conduct county dialogues on HIV, TB sexual and reproductive health and human rights, which have provided fora in which people with TB could articulate their human rights-related grievances and raise awareness about potential recourse, with relevant stakeholders present at the dialogues. In 2019, KELIN also published "Know Your Rights" materials on health, TB and human rights in multiple languages and promoted these via the organization's social media channels.

Additionally, with support from Stop TB partnership, KELIN had identified 40 TB champions from four counties (Mombasa, Kisumu, Homa Bay and Nairobi) to act as advocates on TB issues within their respective counties. The TB champions were trained to monitor the provision of TB services in their communities and advocate for the rights of people with TB by engaging members of their communities and equipping them with knowledge to demand better delivery of TB services. At the time of the MTA, the TB champions sensitized over 993 people from their communities on TB and human rights, through 26 "health talks" targeting people with TB in health facilities, and 17 community sensitization forums targeting key and vulnerable populations and community gatekeepers. In 2021, KELIN also conducted refresher training with the

¹⁰³ Nyumba Kumi Initiative is an approach to policing that brings together the police, civil society and local communities to develop local solutions to safety and security concerns.

¹⁰⁴ MTA report p46

champions on TB and human rights and distributed 700 copies of resources outlining the rights of people with TB, the right to health, and ways to report human rights violations, which the champions will disseminate in their communities.

Progress on the implementation of the MTA recommendations has been limited.

MTA Recommendations	Implementation status		Comments
	YES	NO	
n) Ensure all TB legal literacy efforts include information about the 2018 Tuberculosis Isolation Policy and potential legal recourse for non-compliance, and target county health management stakeholders with training that includes information about the Policy.		X	<ul style="list-style-type: none"> It is not clear that all TB legal literacy efforts include information about the 2018 TB Isolation Policy or that county health management have been targeted with training on the Policy.
o) Once mapping of TB legal literacy efforts has been undertaken, coordinate different interventions for TB legal literacy activities to address gaps in programming.		X	<ul style="list-style-type: none"> It does not appear that this mapping has yet been undertaken.

Progress since the MTA

In line with the drive to integrate TB into HIV human rights and gender programming, KRCS and its SRs have ensured that TB-related rights issues have been incorporated into its legal literacy programs. More information on the scope and coverage of these programs is set out in section 3.2.3 above. KELIN also continues to train paralegals and TB champions to conduct Know Your Rights Campaigns in communities. Unfortunately, the scope, reach and impact of these campaigns is not clear.

Gaps and challenges

Although implementers have integrated TB into their legal literacy programs it is unclear to what extent TB has indeed been fully integrated and the risk remains that the focus of legal literacy programs is more on HIV than it is on TB.

Recommendations

- Map legal literacy efforts related to HIV, TB, malaria, and key and vulnerable populations undertaken by organizations across Kenya to better coordinate, plan and integrate legal literacy activities.

- Review legal literacy materials currently being used to ensure that where TB has been integrated into HIV legal literacy materials, that TB has indeed been fully integrated.
- Support capacity building of HIV, TB and malaria stakeholders and key and vulnerable population led networks to carry out legal literacy training (including in existing HIV, TB and malaria programs), and provide resources for them to sustain and scale up training of peer educators.
- Map key and vulnerable populations for TB and develop user friendly, updated and targeted legal literacy resources on human rights, access to justice and legal services for people living with HIV, TB, malaria and key and vulnerable populations for use by peer educators.
- Consider integrating subject matter on human rights in the context of health in secondary school curricula.
- Ensure all TB legal literacy efforts include information about the 2018 Tuberculosis Isolation Policy and potential legal recourse for non-compliance, and target county health management stakeholders with training that includes information about the Policy.
- Support nationwide and county specific legal literacy campaigns designed to increase public awareness of HIV, TB, malaria, key populations, gender equality and human rights.
- Develop monitoring and evaluation tools to routinely assess coverage and impact of legal literacy efforts disaggregated by sex, gender identity and sexual orientation, and adjust these efforts as necessary.

(e) Increasing access to justice in the context of TB

TB program area	Score		
	Baseline (2021)	Mid-Term (2022)	Progress (2023)
Increasing access to justice in the context of TB	*	1.5	2.3

At the time of the MTA¹⁰⁵ initial work had been undertaken to promote the participation of legal practitioners in cases concerning TB-related rights violations and explore the role lawyers could play in creating an enabling environment for persons suffering from and affected by TB. AMREF, KELIN and NTLD, with support from the Global Fund, conducted sensitization workshops in 2018 in three regions Nairobi / Central / Eastern, Rift Valley/Western and Coastal regions) for 98 lawyers on TB, the law and human rights. An additional 41 lawyers from six counties were also sensitized on various TB-related legal and ethical issues, with the objective of creating a pool of *pro bono* lawyers interested and equipped to participate in legal aid clinics, accept cases and

¹⁰⁵ MTA Report p47

undertake strategic litigation to ensure the protection of the right to health in the context of TB.

In 2019, during Legal Aid Awareness Week, AMREF supported temporary legal aid clinics in Kangemi and Kayole districts in Nairobi, in collaboration with the Law Society of Kenya, targeting residents in informal settlements. KELIN also established legal aid clinics which provide direct legal assistance to individuals living with TB and/or HIV and AMREF and KELIN had collaborated to train paralegals.

Good progress has been made on the implementation of the MTA recommendations:

MTA Recommendations	Implementation status		Comments
	YES	NO	
<ul style="list-style-type: none"> Identify and train peer paralegals to respond to human rights and legal issues most frequently encountered by people living with TB and significantly scale up peer paralegal programming, including in delivery of legal literacy programming. 	X		<ul style="list-style-type: none"> Partially – paralegals are being trained but it is not clear to what extent information on TB-related human rights and rights violations have been properly integrated into the training.
<ul style="list-style-type: none"> Maintain and expand pool of pro bono lawyers willing and able to represent people living with TB and provide ongoing training and support for these lawyers. 	X		<ul style="list-style-type: none"> Kelin continues to train and maintains a database of pro bono lawyers able to represent people with TB.
<ul style="list-style-type: none"> Consider establishment of key and vulnerable population-run hotlines to provide legal information and referrals in response to TB-related rights violations. 		X	<ul style="list-style-type: none"> It does not appear that such a hotline has been established.

Progress since the MTA

There has been some progress in increasing the scale and coverage of the majority of programs to increase access to justice in respect of TB-related human rights violations.

Paralegal training and support

In the period since the MTA, NASCOP and KRCS have both continued to train paralegals. This is covered in detail in section 3.1.4 above. Although the training covers both HIV and TB, it is not clear to what extent TB has been fully integrated into

this training. KRCS has also provided training for the TB Champions on HIV and TB-related law and human rights. As noted in section 3.1.4 above, paralegal training is not standardized either in terms of length or comprehensiveness.

According to data provided by KRCS during this assessment, KRCS SR paralegals resolved a total of 142 cases by way of alternative dispute resolution during 2022 and an additional 30 cases were referred to the courts. It does not appear however that any of these cases were TB-related, which reinforces the concern that TB may not have been fully integrated into paralegal training.

Training and support for pro bono lawyers

Both KELIN and Stop TB have conducted training of and maintain a database of *pro bono* lawyers willing to provide TB-related legal services. KELIN's network of *pro bono* lawyers also offer legal aid clinics in different settings targeting key populations, including legal aid clinics at some methadone clinics, providing an opportunity to integrate legal aid and health services. As with paralegals, the MTA noted a frequent turnover of lawyers who had been sensitized on HIV and human rights, and there is a need to offer continued support and training.

Online directory of legal and social services

KRCS has also, since the MTA, developed an online referral directory of both social and legal services, with a view to improving access to both. Unfortunately, the directory would appear to be largely HIV-focused.

Dialogue with and resources for the judiciary

There do not appear to have been any engagements with the judiciary on TB-related human rights.

Gaps and challenges

This assessment noted the following gaps and challenges in access to justice programming:

- There continues to be a high turnover of paralegals and pro bono lawyers trained on TB and Human Rights and there is thus an ongoing need for training of both paralegals and pro bono lawyers.
- It is unclear to what extent TB has been effectively integrated into existing HIV focused training of paralegals and pro bono lawyers.
- Paralegal training is not standardized (e.g., NASCOP's paralegal training is for 5 days whereas KRCS paralegal training is for 21 days) – there is a need to review and standardize paralegal training curricula and to ensure that the training adequately addresses TB-related human rights and rights violations.
- Sensitization of members of the judiciary on TB, human rights and the law needs to be scaled up.

Recommendations

The following actions are recommended:

- Make provision for ongoing training of both paralegals and pro bono lawyers and ensure that paralegals are paid a reasonable stipend and that payment of ancillary costs are covered by funding to reduce the high turnover of paralegals and pro bono lawyers.
- Review the curricula of NASCOP and KRCS for paralegal training, standardize the curriculum for use across the board and ensure that the training adequately covers TB-related human rights and rights violations.
- Scale up activities to sensitize members of the judiciary on TB, human rights and the law.
- Consider establishment of key and vulnerable population-run hotlines to provide legal information and referrals in response to TB-related rights violations.

(f) Improve laws, regulations and policies related to TB

TB program area	Score		
	Baseline (2021)	Mid-Term (2022)	Progress (2023)
Progress on improving laws, regulations and policies related to TB	1.5	2.0	3.3

At the time of the MTA there had been several notable developments in relation to TB-related law and policy monitoring and reform. In 2016, for example, KELIN won a case before Kenya's High Court, which held that the practice of isolating people living with TB in prisons for the purpose of treatment is unlawful, resulting in a *Tuberculosis Isolation Policy* that requires court authorization prior to such isolation, among other considerations. In 2018, KELIN published an assessment of the TB-related legal environment, providing a critical foundation to inform advocacy to address human rights barriers to TB services. In addition, the Stop TB Partnership and other partners had advocated before the NTLD to develop a social protection framework for TB patients, ensuring more effective and sustainable policies and programs in the realms of medical insurance, cash transfer and nutrition that will cushion TB patients from the catastrophic socio-economic costs which they incur during and after treatment.

The MTA noted that there remains a need to support and enhance the capacity of other civil society organizations and TB stakeholders, particularly those representing key and affected populations, to engage in law and policy monitoring and reform related to TB, particularly at county level¹⁰⁶.

Good progress has been made on the implementation of the MTA recommendations:

MTA Recommendations	Implementation status		Comments
	YES	NO	
p) Sensitize county government, health stakeholders, and key and vulnerable population stakeholders on TB, human		X	<ul style="list-style-type: none"> There is no indication that this has taken place and if it has, it has only been on a very limited scale

¹⁰⁶ MTA Report p48-49

rights and the law, including the 2018 Tuberculosis Isolation Policy.			
q) Develop a standard plan for counties to monitor, document and respond to TB related rights violations and compliance with the Policy, including via use of iMonitor.	X		<ul style="list-style-type: none"> Refer to section 3.2.6 below
r) Adapt iMonitor as necessary, based on the results of the survey of user experiences, and scale up access across all counties by training and equipping civil society organizations and community health volunteers to use the app.	X		<ul style="list-style-type: none"> Refer to section 3.2.6 below
s) Use findings from iMonitor to inform advocacy around TB related law and policy reform.	X		<ul style="list-style-type: none"> Refer to section 3.2.6 below

Progress since MTA

As noted in section 3.3.1 above, there has been progress on policy reform in the employment sector relating to TB. The Public Sector HIV Policy has been updated to include TB and is now a combined HIV/TB workplace policy. In addition, a Workplace Policy on Tuberculosis Disease Management was developed jointly by the Division of National, Tuberculosis Leprosy and Lung Disease-Program (DNTLD-P) of the Ministry of Health in conjunction with the Ministry of Labor, International Labor Organization (ILO), Kenya Federation of Jua Kali Association, Federation of Kenya Employers (FKE), Central Organization of Trade Unions (COTU(K), Kenya Health Federation (KHF) and the Kenya Private Sector Alliance (KEPSA) and was adopted in 2022. One of the stated policy objectives is to eliminate TB-related stigma and discrimination at the workplace.

Gaps and challenges

There is need to support and enhance the capacity of civil society organizations and TB stakeholders, particularly those representing key and affected populations, to engage in law and policy monitoring and reform related to TB, particularly at county level.

Recommendations

- Scale up sensitization of county government, health stakeholders, and key and vulnerable population stakeholders on TB, human rights and the law, including the 2018 Tuberculosis Isolation Policy.
- Support and enhance the capacity of civil society organizations and TB stakeholders, particularly those representing key and affected populations, to engage in law and policy monitoring and reform related to TB, particularly at county level.

(g) Community mobilization and advocacy, including community-led monitoring

TB program area	Score		
	Baseline (2021)	Mid-Term (2022)	Progress (2023)
Community mobilization and advocacy, including community-led monitoring	2.0	3.0	4.0

At the time of the MTA, the Stop TB Partnership was supporting a project in Kisumu and Meru counties to build the advocacy capacities of local communities to address the low allocation of funds to TB services and to strengthen community-based monitoring and reporting of rights violations in relation to TB services. The Stop TB Partnership also supported KELIN to conduct a series of trainings on rights-based approaches to TB care in informal settlements in Nairobi county targeting 180 community health champions to equip them to monitor and respond to TB-related rights violations. In 2020, KELIN also trained 40 TB champions from four counties (Mombasa, Kisumu, Homa Bay and Nairobi) to act as advocates on TB issues within their respective counties. As part of their work, the TB champions will monitor the provision of TB services in local facilities, report violations and use local radio stations for sensitization and advocacy to reach a wider audience. Additionally, KELIN planned to host multi-stakeholder dialogues to provide a platform for the champions to reach policymakers in their respective counties.

AMREF supported the roll-out of the iMonitor app, deployed in collaboration with national and county governments, TAC Health Africa and NEPHAK in Kwale, Vihiga and Homa Bay counties to facilitate feedback on health services and promote local authorities' response.

Good progress has been made in the implementation of the MTA recommendations:

MTA Recommendations	Implementation status		Comments
	YES	NO	
t) Map TB patient and community groups across Kenya to assess geographic, key population, and other gaps in programming, and provide	X		<ul style="list-style-type: none"> • Partially – Mapping of CSOs working on TB has been conducted by KeNAAM but it does not contain sufficient information on programming conducted by each CSO to identify gaps in programming. It is not clear to what

financial support to sustain groups, as necessary.			extent this mapping has been used to raise and provide financial support.
u) Continue support for and increase membership of national network of TB champions and people affected by TB and support opportunities to routinely convene network.	X		<ul style="list-style-type: none"> Support for the TB champions has clearly increased.

Progress since MTA

Substantial progress has been made in programming for community mobilization and advocacy since the MTA. The funding provided by the Global Fund under GC6 for community mobilization and advocacy for HIV and TB is held by AMREF. Interventions to make progress on community mobilization and advocacy for HIV and TB to date include the following:

Institutional capacity building, planning and leadership development

- Building capacity of Networks and CSOs through Organizational Development and Systems Strengthening (ODSS): Under the GC5 and GC6 grants, a total of 598 organizations and networks received ODSS and as at June 2023 1,325 organizations including networks had been reached with mentorship. In addition, 60 AYP led organizations received ODSS and mentoring were also trained and 60 mentored. AMREF is currently working on a graduation plan that will ensure that organizations that have improved are graduated from the ODSS program.

Social mobilization, building community linkages and coordination.

- Training and support for 30 social mobilization champions per county in all the 47 counties: Under GC6 1,325 social mobilization champions were trained. As of June 2023, 1,029 champions were active and receiving a monthly stipend. The champions are conducting activities including awareness creation of HIV, TB and malaria and community led monitoring. They also work together with CHPs during health dialogue and action days and link the communities with the health facility boards community representatives to ensure issues raised by communities are addressed by the health facilities.
- Supporting community actors to participate in national health days (World TB, Malaria and HIV/AIDs days) by organizing and mobilizing participants from different areas/networks as well as supporting the distribution of IEC and BCC materials in 15 counties: Various CSOs/network representatives in each of the 15 counties were facilitated to participate in national health days (World TB, Malaria and HIV/AIDs days) activities at and distribute various IEC and SBCC materials annually.

Community-led advocacy and research

Under GC6 AMREF put out a call for applications for grants for community led and based organizations, networks and civil society actors, particularly those representing marginalized, under-served and key and vulnerable populations for community led research. Out of the 72 applications received, 24 were awarded grants and the research is ongoing.

AMREF also conducted training for 300 Domestic resource mobilization (DRM) Champions who participate in the development of County Development Improvement Plans, as well as in public participation processes for budget monitoring and approval of bills. They also engage in advocacy for the uptake of the National Health Insurance Fund (NHIF).

AMREF also trained 150 citizen advocates who conduct advocacy in collaboration with other community actors based on data gathered through Community Led Monitoring.

Community Led Monitoring

AMREF supports community led monitoring by service users and/or local communities who gather, analyze and use information collected by way of an app “Imonitor ATM+” on an ongoing basis to improve access to, quality and impact of services, and to hold service providers and decision makers accountable. Under GC6 AMREF has upgraded the Imonitor ATM+ tool to enable it to uptake data relating to human rights violations in terms of access to services. AMREF has also trained 33 community actors and GoK staff as Trainers of Trainers on the use of the Imonitor ATM+ tool and by June 2023 had supported the training of 409 peer monitors to use the Imonitor ATM+ tool for CLM in 15 countries. As at June 2023, 12081 issues with access to services were reported through Imonitor.

Community-Led Monitoring is also an integral part of the STOP TB Partnership Global Plan to End TB, which puts people at the center of TB prevention and response. It unites communities, and partners to ensure equitable and equal access to comprehensive people-centered TB services, break down legal and societal barriers to achieving TB outcomes, and fully resource and sustain TB responses while integrating them into health, social protection, and humanitarian systems.

In line with this the STOP TB partnership supported KELIN to conduct an inception meeting in July 2023 in Nairobi, aimed at scaling up the involvement of trained TB affected communities to undertake community-led monitoring for accountability on TB and human rights. The meeting brought together national level stakeholders in the TB response including the National TB Program, Civil Society Organizations, health advocates and TB champions from eight counties to introduce them to One Impact Platform as a tool for Community Led Monitoring. One Impact is Stop TB Partnership’s digital tool that enables people with TB to connect with peers, access TB services and information, and report problems faced while on TB treatment. It also enables national TB programs and other health frameworks to gain access to reliable data that helps them understand the needs and concerns of people affected by TB, which in turn informs service delivery and improves the national TB response. One Impact is four apps in one, comprising of a digital health platform that supports community-based monitoring of the TB response. It includes:

- an app with all you need to know about TB

- an app that helps you access nearby TB health services
- an app that connects you with other people with TB and TB support groups.
- an app that lets you report difficulties in accessing TB services and treatment.

Participants discussed how to best adopt and use One Impact Platform for community led monitoring for accountability in the country and this inception meeting will be followed by convening a meeting with stakeholders to determine the crucial matters to be monitored under the One Impact Platform and training of TB champions from eight (8) counties to implement Community Led Monitoring using the One Impact Platform¹⁰⁷.

The Stop TB Partnership has and is also continuing to provide grants to a number of organizations to strengthen community mobilization and advocacy, as outline in the table below:

Organization	Time frame	Geographic Coverage	Objectives
KELIN	January 2022 - January 2023	Nandi, Makueni, Kajiado, Busia	To strengthen the TB response in Kenya by increasing capacities of affected communities in 4 counties (Nandi, Makueni, Kajiado, Busia) to advocate for rights of people with TB and strengthen networks of affected communities to participate in TB programming and decision making.
Moi's Bridge Community Welfare Association	January 2022- January 2023	Western Kenya counties (Kakamega, Busia, Vihiga and Bungoma)	<ul style="list-style-type: none"> • To increase community participation in TB and human rights programming through the establishment of TB Village Health Community Stakeholders Management Committees representants the community at Sub-county and County level focused on CRG. • To increase and strengthen Community-led Rights and Gender Based Integrated TB and COVID-19 responses and post-test management collaboration at the villages and county level • To participate and engage in TB advocacy and accountability initiatives at national, regional, and global levels.

¹⁰⁷ <https://www.kelinkenya.org/kelin-hosts-inception-meeting-on-community-led-monitoring-for-accountability-in-tb/>

Stop TB Partnership Kenya	January 2022 - January 2023	National	<ul style="list-style-type: none"> To strengthen the multi-sectorial approaches at the nation and sub-national levels for advocacy for domestic resource mobilization towards the achievement of the UNHLM 2022 targets To create a community led participatory and inclusion interventions for sustainable financing for TB response in the wake of Covid-19 To strengthen transparency and accountability for governments in budgeting to ensure sustainable increase in TB allocation and expenditure towards achievements of the UNHLM target.
Kenya Conference of Catholic Bishops	Data not available	Homabay, Kisumu, Siaya and Kakamega Counties	<ul style="list-style-type: none"> To capacity-build vulnerable and marginalized TB communities on CRG issues To increase meaningful engagement of vulnerable and marginalized population structures affected by the community To strengthen the advocacy of vulnerable and marginalized TB communities on CRG for improved TB response
KELIN	May 2023 - April 2024	Mombasa, Kisumu, Homa Bay, Nairobi, Nandi	<ul style="list-style-type: none"> To introduce community led monitoring for accountability tools to national level stakeholders. To increase knowledge of TB champions from eight counties on community led monitoring (CLM) for accountability and support them in undertaking CLM initiatives at the community level. To advocate for prioritization of human rights in the TB response in policies and programming both at the county and national level. To participate and engage in TB advocacy and accountability initiatives at national, regional, and global levels

KELIN	May 2023 – April 2024	Kajiado, Busia and Makueni Counties	<ul style="list-style-type: none"> To strengthen the TB response in Kenya through a participatory community led monitoring for accountability in TB and human rights process
Moi's Bridge Community Welfare Association	May 2023 – April 2024	Kakamega, Busia, Vihiga and Bungoma	<ul style="list-style-type: none"> To increase community participation in TB programming from 60% to 90% through the establishment of 150 additional TB Village Health Community Stakeholders Management Committees (VHCSMC) by 2024 To increase community knowledge and strengthen VHCSMC institutional framework focused on CRG–human rights and other barriers to accessing TB care and related advocacy from 60% to 90% in the villages by 2024. To participate and engage in TB advocacy and accountability initiatives at national, regional, and global levels.
Stop TB Partnership Kenya	May 2023 – April 2024	National level with focus on Siaya, Bungoma, Kirinyaga and Meru Counties	<ul style="list-style-type: none"> To strengthen the capacity of 120 affected communities, 30 CSOs and 47 TB coordinators in CRG for enhanced participation in Community TB response by 2024. To strengthen capacities of 3 new sectors from the MAF listing (MOE, MOI MOT) on CRG for integration in their TB programming by 2024. To strengthen the capacities of 20 CSOs and 100 TB Champions in TB-related rights and gender, community-led monitoring, and accountability by 2024. To participate and engage in TB advocacy and accountability
The Fantasy Soccer	May 2023 – April 2024	Nairobi City, Kitengela Town, Marsabit,	<ul style="list-style-type: none"> To equip refugees with the knowledge and skills to engage

Academy (FSA)		Limuru Town, Rongai Town, Matasia Town, Ngongo Town in Kajiado, Nairobi and Kiambu Counties	<p>in TB prevention and healthy living promoting practices</p> <ul style="list-style-type: none"> • To provide organization development and participatory planning to address stigma, discrimination and establish first-line care services that promote early detection, treatment and good living for refugees and members of the local host communities. • To link the organizations to the Stop TB Partnership in Kenya and other mechanism such as the Global Fund Civil Society Coordination Mechanism and Civil Society Engagement Mechanisms (CSEM). This will ensure effective representation and sustainability of prevention infrastructure targeting both refugees and local host communities. • To participate and engage in TB advocacy and accountability initiatives at national, regional, and global levels.
Stop TB Partnership Kenya	November 2022-May 2024	National	<ul style="list-style-type: none"> • To accelerate engagement of communities for political advocacy towards UNHLM and End TB targets and raise the profile of TB for increased budgetary allocations at the national and county levels

Gaps and challenges

Despite the substantial progress outlined above, investment in community leadership and engagement in public participation and legislative processes for law and policy reforms relating to TB needs to be further scaled up. In addition, it is not clear why two different CLM tools are being used.

Recommendations

In order to strengthen this program area, the following is recommended:

- Continue support for and increase membership of national network of TB champions and people affected by TB and support opportunities to routinely convene the network.
- Ensure the inclusion of KP, especially men who have sex with men and male sex workers, as TB champions.
- Support civil society and key population led organizations to continue and scale up community led monitoring of human rights violations, including violations perpetrated by health care workers towards people with TB, and incorporate findings of such monitoring into training for health care workers and for advocacy purposes.
- Support more community led organizations to conduct CLM using one common CLM tool.
- Ensure collation of CLM data to ensure that data can be used for more efficient programming for advocacy for law and policy reform

(h) Reducing TB-related gender discriminations, harmful gender norms and violence

TB program area	Score		
	Baseline (2021)	Mid-Term (2022)	Progress (2023)
Reducing TB-related gender discrimination, harmful gender norms and violence	0.5	1.0	2.0

The MTA noted that KELIN had produced *Tuberculosis: A Gender Assessment in Kenya* in 2018 which identified that, among other things, women are more likely to seek health care earlier and more frequently than men but face financial barriers to accessing health services, the largely informal labor force in Kenya faces challenges taking time off work to attend health facilities for TB treatment, and there is no data regarding TB and transgender people, despite transgender people being identified as an underserved population in the Gender Assessment. Overall, the Gender Assessment concluded that there was limited evidence regarding the impacts of gender on accessing TB services in Kenya, that the impact of culture and gender on accessing TB services needs to be investigated in all 47 counties, given cultural differences across counties, and recommended a national study in this area to inform effective, gender-responsive TB policies and management.

The *National Strategic Plan for Tuberculosis, Leprosy and Lung Health 2019 – 2023* recognizes the need to mitigate harmful gender norms that are barriers to accessing TB services. At the time of the MTA, most gender-sensitive TB programming had focused on ensuring male engagement. The curriculum for community health volunteer training has been revised to include a package that targets male community health volunteers, and various initiatives to conduct TB screening have focused on male-dominated workplaces in the informal sector, such as truck drivers and quarry workers. While limited, some gender responsive programs were identified in the Gender Assessment. In Kisumu county, the county government has sensitized health care workers to treat a person irrespective of their gender and a community-based health facility (MAAYGO) offers TB and HIV services to transgender people and men

who have sex with men. In Homa Bay county, 24-hour public drop in centers which provide services to sex workers, men who have sex with men and fishermen offer TB screening and links to TB treatment sites. In Busia county, sex workers and men who have sex with men are trained by county community health volunteers on TB and coordinate a support group for TB patients. Key informants interviewed during the MTA acknowledged the need for more gender responsive programming¹⁰⁸.

Some progress has been made on the implementation of the MTA recommendations:

MTA Recommendations	Implementation status		Comments
	YES	NO	
<ul style="list-style-type: none"> Conduct a national study on gender and TB (including TB and transgender people) that also maps and identifies TB key populations across the counties to inform effective, gender-responsive TB policies and management, and based on this study, adapt TB programming to enhance their gender responsiveness. 		X	<ul style="list-style-type: none"> The TB CRG assessment has yet to be finalized.
<ul style="list-style-type: none"> In collaboration with civil society organizations working with transgender people, explore development of training curriculum on transgender health care needs for health care workers and revise the patient hospital triage form so there is an option of 'other' in the gender section (in addition to male and female). 	X		<ul style="list-style-type: none"> This recommendation does not appear to be TB-specific and has been addressed under section 3.2.2.

Progress since MTA

Since the MTA gender-sensitive programming has again focused on reaching males. For example, as noted above, the innovation challenge fund that was provided for in GC6 was utilized to conduct a successful campaign to provide information on TB and related stigma and discrimination targeting the transport sector through community radio reaching a larger number of truck drivers. Overall, there appears to be improved understanding on the part of implementers of how gender impacts on vulnerability to

¹⁰⁸ MTA Report p50

TB and on access to services. However as noted below this understanding can be improved through the undertaking of a TB CRG Assessment.

Gaps and challenges

As indicated in the 2018 TB Gender Assessment, the impact of culture and gender on access to TB services needs to be investigated in all 47 counties, given cultural differences across counties, to better understand the impacts of gender on accessing TB services in Kenya. One of the key informants interviewed for this assessment noted that TB programmers sometimes overlook gender dynamics when designing programs. For example, the majority of nurses are women and men, who are more impacted by TB, very often do not want to be treated by a woman and as a result they do not come for treatment. Another example provided by the key informant is that MDR patients receive a social allowance but men are traditionally the breadwinners so if it is a woman with MDR and they receive the allowance this causes tension in the home¹⁰⁹. The planned Community Rights and Gender (CRG) assessment has however yet to be finalized. In addition, there is currently no TB specific costed operational framework for gender-sensitive and gender transformative interventions, nor are there any county level strategic plans that address human rights and gender-transformative issues.

Recommendations

- Ensure that the TB CRG assessment is finalized and the results used to establish baselines and to inform programming.
- Consider developing a costed operational plan for CRG interventions at national and county levels.
- Ensure that the new National Strategic Plan for Tuberculosis, Leprosy and Lung Health recognizes the need to mitigate harmful gender norms that are barriers to accessing TB services.
- Support the scale up of gender sensitive and gender transformative programs to reduce vulnerability to TB and ensure access to TB services.
- Support the provision of technical assistance on the design of programs to reduce human rights and gender related barriers to TB services.

(i) Programs in prisons and other closed settings

TB program area	Score		
	Baseline (2021)	Mid-Term (2022)	Progress (2023)
Progress on programs in prisons and other closed settings	1.0	1.5	2.0

As noted at baseline and in the MTA, significant prison overcrowding and inadequate infrastructure for infection prevention or control are issues for TB prevention and control. Some prisons do not have onsite health facilities or have understaffed health facilities that lack adequate supplies and face delays in getting TB tests results, while

¹⁰⁹ Key Informant Interview, Stop TB Kenya representative 30 May 2023.

some prison staff are not appropriately trained to recognize the symptoms of TB, maintain patient confidentiality, prioritize TB screening, or facilitate linkages for prisoners to health care after release. As at mid-term NACC, in conjunction with HIV and TB partners, carried out activities to train 382 prison personnel on the linkages between public health and human rights and HIV and TB responses, including 40 leadership command officers at central level, and 70 regional and main prisons command officers. In the coast region, the AIDS Control Unit of the Kenya Prison Service had carried out some sensitization of prison staff on HIV and TB, including the training of non-clinical officers to recognize the symptoms of TB to meet high demand for early referral, and information. Reachout had also provided paralegal support to prisoners in Mombasa, and offered HIV testing and counseling, health education and psychosocial support to women in Shimo la Tewa prison.¹¹⁰

MTA Recommendations	Implementation status		Comments
	YES	NO	
v) Develop training materials on HIV, TB and human rights in prisons for all prison staff, disseminate the training materials to prison authorities, and coordinate training with Kenya Prison Service.	X		<ul style="list-style-type: none"> Training materials have been developed By NTLP.
w) Facilitate the establishment of psychosocial support groups to address internalized stigma among prisoners with HIV or TB.	X		<ul style="list-style-type: none"> Peer educators have been identified in prisons to provide information on TB and to encourage screening and treatment adherence but there is no indication that psychosocial support groups have been established.
x) Develop and deliver human rights training for civil society organizations advocating for prisoners' rights and health, including topics such as the need to maintain privacy and confidentiality, the right to access HIV and TB testing and treatment, safer sex supplies and opioid agonist therapy in prison, and the need for prison infrastructure improvements.		X	<ul style="list-style-type: none"> As above.

¹¹⁰ MTA Report p56

y) Develop and implement a protocol to link prisoners and individuals recently released from prison living with HIV, TB or malaria with health facilities equipped to address HIV, TB or malaria and community psychosocial supports.	X		<ul style="list-style-type: none"> The NSP End term review noted that linkages are good.
z) Develop materials and deliver legal literacy training for prisoners to act as peer human rights educators in prison.		X	<ul style="list-style-type: none"> There is no indication that this recommendation has been implemented.
aa) Establish and roll out mobile legal services in prisons in preparation for various court proceedings.		X	<ul style="list-style-type: none"> As above.

Progress since the MTA

There has been some progress since the MTA. The End Term Review of the TB NSP found that regular active case finding with symptom screening is being conducted in most prisons, on entry and thereafter at varying frequency, depending on the prison. Healthcare is provided to prisoners for free and covered by NHIF, with people with TB or HIV receiving a double ration of food and nutrition supplements. The latest policies and data tools were largely in place, with some prisons documenting outcomes for all prisoners who had been released or transferred. There was linkage and follow-up for those released prior to treatment completion at the community level through linkage assistants supported by implementing partners. The review team noted All prisons have had roof turbine vents installed to improve air circulation for TB/COVID-19 IPC, with quarantine facilities provided for inmates with TB and DR TB. However, Linkage to ART services was noted to be high among HIV positive prisoners.¹¹¹ Amref Health Africa in collaboration with DNTLD-P offers TB screening using x-ray machines to prisoners/wardens and those in remand in outreach activities at prisons in selected counties (high volume prisons) and intensively through KIC TB in Kiambu and Nairobi counties.

NSDCC has planned a knowledge and attitude assessment of police and prisons services on key HRG related issues to TB and HIV response before the end of 2023. NTLP has developed training materials for prison officers on TB and human rights and has identified peer educators from amongst prison inmates. KRCS SRs offer TB screening to KPs (MSM, PWID, SW) in their outreach activities at hotspots.

Gaps and Challenges:

¹¹¹ Report of the End-Term Review of the National Tuberculosis, Leprosy and Lung Health Strategic Plan, 2019-2023 p51

- There has been variable progress in implementation of TPT services in prisons. While some prisons received TPT commodities, trained staff and offered TPT to all eligible inmates (except children) others are awaiting formal communications from the prison authorities before starting inmates on TPT.
- Ventilation and lighting in the TB isolation cells is often inadequate.

Recommendations

- Ensure that training materials on TB and human rights in prisons are integrated into Prison Service pre- service and in-service training.
- Facilitate the establishment of psychosocial support groups to address internalized stigma among prisoners with TB.
- Develop materials and deliver legal literacy training for prisoners to act as peer human rights educators in prison.
- Support advocacy for the implementation of non-custodial sentencing to relieve overcrowding in prisons.

3.3 Programmes to remove barriers to malaria services

Adherence to human rights, gender and equity is one of the guiding principles of The *Kenya Malaria Strategy (KMS) 2019-2023*. As noted in the MTA, the concept of removing human rights-related barriers to malaria services is still relatively new to stakeholders in the malaria response in Kenya. Many of the barriers to malaria services overlap with those affecting access to primary health care, such as distance to health facilities, cost of transportation, and drug and commodity stockouts. These barriers are amplified in rural areas and are particularly pronounced among people living in poverty, women, mobile populations, and prisoners. Other populations that are vulnerable to malaria include pregnant women and adolescents, children, adolescents and young adults, people living with HIV, rural populations, and people with disabilities. The MTA found that, consistent with the findings at baseline, scant programs were identified to address human rights-related barriers to malaria services, and commodities and service delivery remains the focus of most malaria programming, which key informants attributed to limited resources and human rights expertise.¹¹²

(a) Reducing gender related discrimination and harmful gender norms

Malaria program area	Score		
	Baseline (2021)	Mid-Term (2022)	Progress (2023)
Progress on reducing gender related discrimination and harmful gender norms	0	0.5	1.0

¹¹² MTA p 53

The baseline assessment identified malaria prevention strategies focused on pregnant women, women and children under five, but did not identify specific programming to reduce gender-related barriers and harmful gender norms, and this remained true at mid-term, despite the fact that the Kenya Malaria Strategy 2019-2023 affirms that “malaria interventions will be implemented to ensure gender equity and responsiveness.” There is a notable dearth of research investigating the role of gender inequality in relation to malaria¹¹³.

Limited progress has been made in the implementation of the MTA recommendations:

MTA Recommendations	Implementation status		Comments
	YES	NO	
Strengthen health management information system by routinely collecting sex and age disaggregated data on malaria and analyzing results to enhance gender responsiveness of malaria programming.		X	<ul style="list-style-type: none"> Malaria program implementers indicated that this be provided for under the new National Malaria Strategy.
Mainstream gender issues, including an understanding of how gender dynamics surrounding malaria can influence malaria and health through access, treatment, decision making, and exposure, at all levels of malaria program design, implementation, and evaluation.		X	<ul style="list-style-type: none"> As above
Strengthen the capacity of key malaria stakeholders, managers and data analysts to understand, analyze, prioritize, and use gender related information, including in future Kenya Malaria Strategy.	X		<ul style="list-style-type: none"> Although there has been slight progress on this, efforts will be ramped up under the new National Malaria Strategy.
Support community education on gender equality and patients' rights to be delivered alongside malaria social and behavioral change	X		<ul style="list-style-type: none"> As above

¹¹³ ibid

campaigns, with messages targeted at different groups including mothers, pregnant women, men, fathers, adolescents, community leaders, religious leaders, refugees and schoolchildren. In addition to focusing on identification of malaria symptoms, prevention and timely health seeking behaviors, campaigns could integrate information on more equitable household decision making, the sharing of caregiving activities, the need for men to support their partners to seek care in a timely manner without permission, and challenging harmful gender norms.			
---	--	--	--

Progress since the MTA

A malaria matchbox assessment¹¹⁴ was conducted in 2022 that identifies specific strategies to reduce gender-related barriers and harmful gender norms. The report identified pregnant women and children under the age of 5 as being the primary groups being left behind in terms of malaria prevention and treatment. In addition, the assessment reported that access by pregnant women to ANC services is often hampered by power dynamics in relationships in terms of which men control women's access to health services. In addition, the teenage pregnancy rate is relatively high¹¹⁵ and pregnant teenagers face negative societal perceptions regarding early pregnancies and avoid health facilities for fear of stigmatisation. The assessment report is however yet to be launched¹¹⁶. The current National Malaria Strategy, which has adopted HRG as a guiding principle, comes to an end in December 2023. A new malaria strategy to be developed once the malaria sector plan review is finalised, which will incorporate and be guided by the findings and recommendations from the matchbox assessment. The National Malaria Program has placed a high priority on integrating gender and human rights perspectives, as well as emphasizing community engagement in the implementation of the Malaria Matchbox findings in the GC7 Global Fund Malaria Funding Request. The GC6 implementation provided a foundation for the engagement of key vulnerable populations (KVP) through a targeted malaria campaign. The program identified the different KVPs, co-created campaign messages

¹¹⁴ An equity assessment tool, designed to support the identification of populations or individuals most affected by malaria and underserved by malaria interventions, as well as the key equity- human rights- and gender-related barriers disproportionately affecting malaria outcomes in those populations

¹¹⁵ The KDHS 2022 reported the teenage pregnancy rate as 15%

¹¹⁶ Key Informant Interview National Malaria Program representative.

and established a malaria repository at the National and County level with malaria campaign content in formats, and channels appropriate for the KVPs¹¹⁷.

Gaps and challenges

There is a dearth of research investigating the role of gender inequality in relation to malaria and data on malaria that is disaggregated on the basis of age and gender, which would facilitate an analysis of the results to enhance the gender responsiveness of malaria programming, is not currently available. In addition, there is a relative lack of HRG expertise amongst malaria program implementers.

Recommendations

- Disseminate findings of the matchbox assessment to key stakeholders and utilize the findings of the matchbox assessment to inform the content of the new National Malaria Strategy.
- Strengthen health management information system by routinely collecting sex and age disaggregated data on malaria and analyzing results to enhance gender responsiveness of malaria programming.
- Support community education on gender equality and patients' rights to be delivered alongside malaria social and behavioral change campaigns, with messages targeted at different groups including mothers, pregnant women, men, fathers, adolescents, community leaders, religious leaders, refugees and schoolchildren. In addition to focusing on identification of malaria symptoms, prevention and timely health seeking behaviors, campaigns could integrate information on more equitable household decision making, the sharing of caregiving activities, the need for men to support their partners to seek care in a timely manner without permission, and challenging harmful gender norms.
- Strengthen the capacity of key malaria stakeholders, managers and data analysts to understand, analyze, prioritize, and use gender related information, including in future Kenya Malaria Strategy.
- Strengthen the capacity of key malaria stakeholders and implementors on HRG at all levels of programme design, implementation and evaluation.

(b) Promoting meaningful participation of affected populations

Malaria program area	Score		
	Baseline (2021)	Mid-Term (2022)	Progress (2023)
Progress on promoting meaningful participation of affected populations	0.5	1.5	2.0

At baseline assessment it was noted that KeNAAM facilitated the participation of civil society organizations in the national Malaria Program Review in 2018, which was designed to feed into the *Kenya Malaria Strategy (KMS) 2019-2023*. This resulted in the adoption of human rights and gender as guiding principles in the strategic plan, providing a foundation from which to develop and implement human rights programs, in addition to the reconvened human rights and gender technical working group on HIV, TB and malaria which includes, for the first time, malaria stakeholders.

¹¹⁷ *ibid*

As noted in the MTA, KeNAAM carried out a rapid mapping of malaria civil society organizations in 2021 to inform the Malaria Matchbox Assessment that was scheduled to be undertaken in 2021. KeNAAM also consulted with and conducted training to build the capacity of those organizations to meaningfully engage in the assessment. An introductory training curriculum for civil society organizations was developed that included content on human rights, vulnerable populations, non-discriminatory health care, gender as a determinant of health and gender roles in the context of malaria, and KeNAAM conducted four virtual training sessions for 36 representatives from civil society organizations. As one key informant noted during the MTA, civil society organizations working on malaria are “way ahead of [government] actors on human rights and gender” and have helped “demystify and share what human rights might look like in malaria.”¹¹⁸

Progress on the implementation of the MTA recommendations has been mixed:

MTA Recommendations	Implementation status		Comments
	YES	NO	
Scale up and deliver training for all malaria civil society organizations identified via the mapping to inform the Malaria Matchbox Assessment, to enhance their capacity to participate in policy design and monitoring of implementation.	X		<ul style="list-style-type: none"> This was undertaken by KeNAAM.
Support community centered elements of the malaria response, such as county and regional networks of malaria civil society organizations, to engage in advocacy efforts at the county and national level.		X	<ul style="list-style-type: none"> This recommendation has yet to be implemented.
Sensitize malaria duty bearers, including authorities within the Ministry of Health and the National Malaria Control Program, of the importance of community engagement.	X		<ul style="list-style-type: none"> Although work has started on this, this work needs to be substantially scaled up particularly at county level.
Identify civil society malaria stakeholders to join reconvened human rights and gender technical working group on HIV, TB and malaria.	X		<ul style="list-style-type: none"> KeNAAM has completed the mapping exercise. It is however not clear to what extent efforts have been made to identify civil society malaria stakeholders to join the Joint

¹¹⁸ MTA Report p55

			HIV, TB and Malaria Human Rights and Gender TWG.
Disseminate the key findings of the Malaria Matchbox Assessment to the broader public via a social media campaign, developed in collaboration with KeNAAM and malaria civil society organizations, and collaboratively develop plan to respond to and address key findings.		X	<ul style="list-style-type: none"> This recommendation has yet to be implemented.

Progress since the MTA

KeNAAM completed a mapping of Kenya CSOs working on Malaria, HIV and TB in 2022. Although the mapping report did not indicate how many CSOs were engaged in HRG programming for malaria, it did provide data on how many organizations were covering the different key and vulnerable populations in the context of malaria. Most of the CSO's respondents are working with communities in informal settlements (23%), followed by Persons with Disabilities (19%), indigenous communities (16%), fishing communities (13%), hard to reach populations and prisons (6% each), and refugees (3%). Only a small portion of the CSO respondents is covering all the KVP (6%)¹¹⁹.

Capacity building interventions with CSOs working in the malaria sector are ongoing to enhance their capacity to participate in policy design and monitoring of implementation. In addition, community health promoters are being trained to provide access to medicine and diagnostics for vulnerable groups e.g. the fishing community and seasonal workers who face challenges, such as lack of protection and sleeping space¹²⁰.

Gaps and challenges

Work to ensure the meaningful participation of affected populations has commenced but needs to be scaled up substantially. In addition, the participation of representatives of malaria program implementers and in particular of affected communities in the HRG TWG is sub-optimal.

Recommendations

- Scale up and deliver training for all malaria civil society organizations identified via the mapping exercise, and in particular those that represent or are led by affected communities, to enhance their capacity to participate in policy design and monitoring of implementation.

¹¹⁹ Mapping report p17

¹²⁰ Key informant interview National Malaria Program representative 20 June 2023

- Support the strengthening of community centered elements of the malaria response, such as county and regional networks of malaria civil society organizations, to engage in advocacy efforts at the county and national level.
- Sensitize malaria duty bearers, including authorities within the Ministry of Health and the National Malaria Control Program, on the importance of community engagement, particularly by affected communities.
- Identify civil society malaria stakeholders to join the Joint HIV, TB and Malaria HRG TWG.
- Disseminate the key findings of the Malaria Matchbox Assessment to the broader public via a social media campaign, developed in collaboration with KeNAAM and malaria civil society organizations, and collaboratively develop a plan to respond to and address key findings.

(c) Strengthening community systems for participation in malaria programs

Malaria program area	Score		
	Baseline (2021)	Mid-Term (2022)	Progress (2023)
Progress on strengthening community systems for participation in malaria programs	*	2.0	2.0

As noted in the MTA, community health volunteers are frequently deployed to deliver malaria-related services including community case management and the provision of malaria information. For example, with Global Fund support, AMREF supports a network of community health volunteers in ten high-burden counties who regularly visit households to conduct malaria testing, treatment and referral of severe cases to health facilities. The U.S. President's Malaria Initiative (PMI) has supported county health management teams to train community health volunteers and community health assistants to identify and address signs of malaria, especially among children and pregnant women. The Ministry of Health has also spearheaded a "Mass Net Distribution Campaign" every three years in 27 high-burden counties, involving community sensitization, training of health care workers and community health volunteers, registration of households, and distribution of nets at fixed posts. According to key informants, because malaria is not subject to stigma in the way that HIV and TB are, community health volunteers can engage in a broad range of activities including information and support around reproductive health and sanitation; they also present an opportunity to sensitize target audiences on human rights and gender barriers to malaria services. However, the mid-term assessment was unable to assess the extent to which community health volunteers incorporate human rights or legal literacy in their work.

The MTA also noted that the 2019 court ruling brought forward by the regulatory body that licenses laboratory technologies and technicians, which ruled that community health volunteers are not permitted to administer malaria (and other) testing has had

negative implications not only for malaria, but also for HIV and TB, on the involvement of community health volunteers in the management of HIV and TB¹²¹.

Progress on implementing the MTA recommendations has been limited:

MTA Recommendations	Implementation status		Comments
	YES	NO	
bb) Review existing training curricula for community health volunteers to ensure inclusion of malaria related gender and human rights concerns and support training of community health volunteers to understand human rights and gender barriers to malaria services.		X	<ul style="list-style-type: none"> It does not appear that this recommendation has been implemented as yet.
cc) Continue 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.	X		<ul style="list-style-type: none"> This advocacy is ongoing. Currently testing is being conducted by community health volunteers but the risk of litigation remains.
dd) Expand iMonitor to enable community monitoring of malaria service delivery and train community health volunteers and malaria civil society organizations in use of this tool.		X	<ul style="list-style-type: none"> It does not appear that this recommendation has been implemented as yet.

Progress since the MTA

Interventions identified by the MTA have been continued but there does not appear to have been any scale up of these interventions. AMREF has continued to support a network of community health volunteers in 10 high-burden counties who regularly visit households to conduct malaria testing, treatment and referral of severe cases to health facilities¹²². In addition, the U.S. President's Malaria Initiative (PMI) has also continued to support county health management teams to train community health volunteers and community health assistants to identify and address signs of malaria, especially among children and pregnant women¹²³. The Ministry of Health has also continued its

¹²¹ MTA Report p56

¹²² Key Informant Interview with AMREF representative

¹²³ Key Informant Interview with PMI representative

“Mass Net Distribution Campaign” (every three years) in 27 high-burden counties, involving community sensitization, training of health care workers and community health volunteers, registration of households, and distribution of nets at fixed posts. As noted above, the National Malaria Program has placed a high priority on integrating gender and human rights perspectives, as well as emphasizing community engagement in the implementation of the Malaria Matchbox findings in the GC7 Global Fund Malaria Funding Request¹²⁴.

Gaps and challenges

- Limitations in the monitoring tools used in the field currently means that they are not able to capture all relevant data or prioritize community involvement accurately and thus have limited usefulness for community monitoring of malaria service delivery.
- The 2019 court ruling in terms of which community health volunteers are not permitted to administer malaria (and other) testing. The NMCP thus updated its testing guidelines for CHPs requiring, among other things, only trained and certified community health volunteers to implement testing as well as regular supervision of such testing by registered laboratory personnel but this limits the capacity of the program to expand testing reach.

Recommendations

- Review existing training curricula for community health volunteers to ensure inclusion of malaria related gender and human rights concerns and support training of community health volunteers to understand human rights and gender barriers to malaria services.
- Continue 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.
- Expand iMonitor to enable community monitoring of malaria service delivery and train community health volunteers and malaria civil society organizations in use of this tool.

(d) Monitoring and reforming laws, policies and practices

Malaria program area	Score		
	Baseline (2021)	Mid-Term (2022)	Progress (2023)
Monitoring and reforming laws, policies and practices	*	*	0

This program area was not assessed in either the baseline or mid-term assessments. The MTA noted however that the 2019 court ruling brought forward by the regulatory body that licenses laboratory technologies and technicians, which ruled that community health volunteers are not permitted to administer malaria (and other) testing has had negative implications not only for malaria, but also for HIV and TB, on the involvement of community health volunteers in the management of HIV and TB¹²⁵.

¹²⁴ Key Informant Interview with National Malaria Program representative.

¹²⁵ MTA Report p56

Gaps and challenges

This assessment was not able to identify any programs focused on monitoring and reforming laws, policies and practices.

Recommendations

- Engage in and support 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.

(e) Improving access to services for underserved populations

Malaria program area	Score		
	Baseline (2021)	Mid-Term (2022)	Progress (2023)
Progress on improving access to services for underserved populations	1.0	1.0	1.0

As noted in the MTA, malaria continues to be a key health issue for refugee populations in Kenya. At mid-term, the UNHCR continued to distribute bed nets and insecticides to refugees and asylum-seekers in Kakuma camp and Kalobeyei Integrated Settlement, and works with partners to provide free health services, including rapid malaria tests and malaria treatment, to residents of the camp and settlement. The Kenyan government also provides people living with HIV free access to long-lasting insecticide-treated nets as part of the HIV Basic Care Package. At mid-term, no other programs were identified to enhance access to malaria services for refugees and others affected by emergencies or for people living with HIV.

Critically, neither the baseline nor mid-term assessments were able to engage directly with underserved populations in the malaria response, nor with the service implementers who operate in these settings. This is a significant gap in understanding how underserved populations experience rights-related barriers to access services¹²⁶.

There has been little or no progress on the implementation of the MTA recommendations.

MTA Recommendations	Implementation status		Comments
	YES	NO	
Disseminate key findings of the Malaria Matchbox Assessment related to underserved populations to key stakeholders, including the Ministry of Health, the National Malaria Control Program, the		X	<ul style="list-style-type: none"> It would appear that the findings of the Malaria Matchbox Assessment are yet to be released.

¹²⁶ MTA Report p57

human rights and gender technical working group on HIV, TB and malaria, and malaria program implementers in refugee settlements to better understand key areas for improvement to remove existing human rights related barriers to access services.			
Increase legal literacy for underserved communities to know their rights and support them to mobilize and hold duty bearers accountable. This includes engaging humanitarian stakeholders to ensure the refugee populations (and other affected by emergencies) are provided with tools and information to understand their health related rights, including in the context for malaria.		X	<ul style="list-style-type: none"> This assessment was not able to find any evidence of scaled up legal literacy for underserved populations.

Progress since the MTA

The Kenyan government continues to provide PLHIV free access to long-lasting insecticide-treated nets as part of the HIV Basic Care Package. The UNHCR also continues to distribute bed nets and insecticides to refugees and asylum-seekers in Kakuma camp and Kalobeyi Integrated Settlement, and works with partners to provide free health services, including rapid malaria tests and malaria treatment, to residents of the camp and settlement.

Gaps and challenges

A key informant interviewed during this assessment identified a number of ongoing gaps and challenges in respect of reaching underserved populations:

- Undocumented migrants are unable to access free bed nets through the Ministry of Health's distribution program as they do not have identity documents that are required to access the free nets¹²⁷.
- In order to access free bed nets through this distribution program people are required to be registered at their permanent place of abode. This poses a problem for people who move around for their work such as truck drivers, informal traders who move from market to market, seasonal workers and fisherfolk.

¹²⁷ Key informant interview: KeNAAM representative

- Treatment for malaria is available at all public health facilities but they are only open from 8am to 5pm which means that people who are employed during the day are very often unable to access this service without losing a day of income.
- Seasonal workers are often accommodated in very overcrowded accommodation which makes it impossible for bed nets to be hung. The situation is similar for students at boarding schools living in overcrowded dormitories. In addition, teachers are often not adequately trained to recognize malaria symptoms, especially in areas where malaria is not endemic, which results in students with malaria presenting late for malaria treatment.
- The elderly and people with disabilities are often neglected when it comes to indoor residual spraying as everything is required to be moved out of the house for spraying to take place and the elderly and people with disabilities are unable to do this.

Recommendations

- Disseminate key findings of the Malaria Matchbox Assessment related to underserved populations to key stakeholders, including the Ministry of Health, the National Malaria Control Program, the human rights and gender technical working group on HIV, TB and malaria, and malaria program implementers in refugee settlements to better understand key areas for improvement to remove existing human rights related barriers to access services.
- Engage with implementers operating in the refugee camps to map who and what services are being offered by partners working on behalf of UNHCR and related agencies.
- Revise the policy on free bed net distribution to ensure that they reach underserved populations such as truckers, informal traders, fisherfolk and others.
- Engage with the Federation of Kenya Employers and with trade unions to ensure that employees are able to access malaria testing and treatment without losing income and also to ensure that seasonal workers are accommodated in accommodation that permits the hanging of individual bed nets.
- Engage with the Ministry of Education to ensure that students at boarding schools are similarly accommodated in dormitories that allow the hanging of individual bed nets and also to ensure that teachers and matrons are trained to recognize early symptoms of malaria.
- Consider the development of a phone app, similar to that used by the KRCS for HIV and TB, to provide easily accessible information on malaria and where to obtain testing and treatment. Alternatively integrate malaria information into the existing app.
- Increase legal literacy for underserved communities to know their rights and support them to mobilize and hold duty bearers accountable. This includes engaging humanitarian stakeholders to ensure the refugee populations (and other affected by emergencies) are provided with tools and information to understand their health-related rights, including in the context for malaria.

4. National Ownership and Enabling Environments to Address Human Rights-related Barriers

This section discussed two cross-cutting components of the progress assessment: improvements in national ownership for reducing or removing barriers, and important trends in the program environment that either enable or impede progress to remove barriers.

Improvements in national ownership for reducing or removing human rights- and gender-related barriers to HIV, TB and malaria services are evidenced by the adoption of the *Kenya AIDS Strategic Framework (KASF II) (2020/2021 - 2024/2025)*, as well as the *National Strategic Plan for Tuberculosis, Leprosy and Lung Health 2019-2023*. ('the TB NSP'), and the *Kenya Malaria Strategy 2019-2023*, all of which have a strong emphasis on the removal of human rights and gender related barriers¹²⁸. In addition, the country's clear commitment to reducing human rights and gender related barriers to HIV, TB and malaria services is outlined in the *Strategic Plan: Comprehensive response to human rights and gender-related barriers to HIV, TB and Malaria services in Kenya (2021-2024)*. The aim of the Human Rights Plan is to provide a supportive, human rights-based and gender-transformative policy environment for the implementation of HIV, TB and malaria programs that reduce new infections, AIDS, TB and malaria related deaths and discrimination against people living with HIV and other key and vulnerable populations in the context of HIV, TB and malaria. This plan has been developed to set out a comprehensive integrated response to human rights and gender related barriers to HIV, TB and malaria services in Kenya, as well as a monitoring and evaluation framework, which will facilitate better coordination and strategizing for the effective scale-up of programs to remove human rights and gender-related barriers to an effective HIV, TB and Malaria response. The plan reinforces and complements commitments under the *Kenya AIDS Strategic Framework (KASF II) (2020/2021 - 2024/2025)*, as well as the *National Strategic Plan for Tuberculosis, Leprosy and Lung Health 2019-2023*. ('the TB NSP'), and the *Kenya Malaria Strategy 2019-2023* to follow human-rights-based and gender sensitive principles and approaches that leave no one behind. It further reinforces the country's commitments under *2021 Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030* and the African Union's *Catalytic Framework to End AIDS, TB and Eliminate Malaria by 2030*.

The plan promotes inclusive, multisectoral approaches to HIV, TB and malaria to reduce inequalities, protect human rights and strengthen collaboration and synergies between HIV, TB and malaria-specific and broader health and development initiatives and systems at all levels. It also seeks to advance a whole-of-government, whole-of society response to HIV, TB and malaria and to strengthen inclusive, transparent, accountable and multisectoral governance mechanisms to effectively support inclusive, multisectoral strategic partnerships, coordination and collaboration. One of its specific objectives is to strengthen the leadership, accountability and coordination of human rights and gender transformative responses to HIV, TB and malaria,

¹²⁸ See para 2.5 above for further details on these plans.

including through strengthening the capacity of the national HIV, TB and Malaria Joint Human Rights Technical Working Group (TWG) to (a) enhance the coordination of implementers engaged in programming for the reduction of human rights and gender-related barriers to HIV, TB and malaria services and (b) to continuously monitor the implementation of the plan and ensure quality of activities and interventions through capacity strengthening on design and implementation and scaling up of programs and on quality assurance and effective monitoring and evaluation of programs. The TWG is co-chaired by NSDCC and a civil society representative. In addition to the TWG at national level, Human Rights and Gender TWGs have been established at county level in all 47 counties.

Most key informants interviewed in the course of this assessment were aware of the existence of the TWG and were in fact members of the TWG. Opinions were varied concerning the current effectiveness of the TWG in terms of its coordinating and quality assurance functions.

Key Informants Views on the Human Rights TWG	
Positive Aspects	Challenges
"The TWG always reaches out to you, especially on the issue of human rights. We always feel that we are involved in the discussions and also in some of the implementations that have been taking place.'The TWG has been reaching out to us for participation. I think the work that was done by the TWG has been very positive in terms of bringing us together, letting us know what is happening and to learn from each other. This helps us to implement in certain areas".	"It does not meet often enough to share what is being done and members are not acting on the recommendations of TWG. The County TWGs need to be strengthened".
"The TWG has been used as a vehicle to train members on HIV, TB, Malaria and human rights. There is however a need for continued capacity building and sensitizations especially due to emerging science across the three diseases as the members need to be continuously updated".	"We need to figure out how to use the TWG to get implementers to amend their programming to reflect and respond to data".
'I think for the Human Rights Technical Working Group, compared to how it was previously, my own opinion is that in this current grant, the technical working group has been effective in terms of the coordination of meetings that has happened on quarterly basis without fail. And each of the different implementer, we're able to share the progress of what we are doing and get even feedback from the other members. And then I've seen a lot of support, especially when we're implementing, we have a lot of consultancy for the different activities. And when we call upon	In terms of engagement, I think we can do better in terms of engagement because I know I'm a member, but I've never been to a meeting.

the TWG members to support. I have seen a lot of support in the different work that we are doing. Maybe what maybe need to happen more is to ensure that the feedback given during such forums are followed up, like the different things that are coming up, so that when we have this meeting, then we are not discussing new things and leaving out the ones that were discussed previously”.	
“You are invited in the TWG to make your position, then you're able to hear what are the challenges the things you are experiencing. That is now when I'm able to come and just to see how best to unlock some of these challenges”.	“There are not enough representatives of people working on malaria and TB on the TWG and TB and malaria programming are not often on the agenda for discussion”.
“Through the TWG for the first time in Kenya, we were able to develop a human rights and gender plan just to guide the country on how to respond to human rights and gender issues in HIV, TB and malaria. There is a lot of collaboration regarding even implementation of activities. The TWG has facilitated a creation of synergies, especially when, let's say in undertaking an activity on sensitization of matrons or the education officers. We don't go to that activity just speaking around HIV alone”.	“Some key stakeholders are missing from the TWG membership, eg the Ministry of Education.”

In general, it appears that while the Joint HIV, TB and Malaria Human Rights TWG provides a mechanism for co-ordination of implementation, the challenges referred to above compromise the ability of the TWG to be wholly effective in this function. In addition, it would seem that the TWG does not currently play a significant role in quality assurance of programming.

This may be attributable to some extent to the fact that there is a no common set of outcome level indicators and targets, and a comprehensive monitoring and accountability mechanism.

Conclusion and Recommendations

In order to strengthen the capacity of the Joint HIV, TB and Malaria Human Rights TWG to enhance the coordination of implementers engaged in programming for the reduction of human rights and gender-related barriers to HIV, TB and malaria services, to monitor the implementation of the plan and ensure quality of activities and interventions through capacity strengthening on design and implementation and scaling up of programs and on quality assurance and effective monitoring and evaluation of programs, the following is recommended:

- Establish a calendar for routine meetings of the TWG linked to monitoring and reporting of progress of interventions to reduce or remove barriers.
- Develop and implement a monitoring and accountability framework for the implementation of the *Strategic Plan: Comprehensive response to human rights and gender-related barriers to HIV, TB and Malaria services in Kenya (2021-2024)*.
- Develop a digitized system for reporting on progress on programming to reduce human rights and gender related barriers.
- Review the membership of the TWG to ensure that all key stakeholders are represented.
- Strengthen the capacity of the national and country Joint HIV, TB, Malaria & Human Rights Technical Working Groups (TWG) and secretariat to (a) enhance the coordination of implementers engaged in programming for the reduction of human rights and gender-related barriers to HIV, TB and malaria services and (b) to continuously monitor the implementation of the plan and ensure quality of activities and interventions through capacity strengthening on design and implementation and scaling up of programs and on quality assurance and effective monitoring and evaluation of programs.

5. Key Recommendations

5.1 Recommendations for Programs to Reduce Barriers to HIV Services

The following recommendations are proposed to strengthen programs to reduce human rights-related barriers to HIV services.

Program Area	Recommendations
Eliminate stigma and discrimination in all settings.	<ul style="list-style-type: none"> • Conduct a Stigma Index 3.0 Survey to inform future stigma and discrimination reduction programming and consider expanding the scope of the survey or conducting an additional survey to capture the attitudes of the general population towards people living with HIV. • Scale up sensitization and institutional support to teachers and county education officers in all counties to address HIV and TB-related stigma and discrimination and GBV. • Scale up programming to address internalized stigma. • Scale up programming to address HIV-related stigma and discrimination in family settings. • Ensure the meaningful participation of PLHIV and KP in the design and implementation of stigma and discrimination reduction programs. • Scale up the implementation and enforcement of workplace policies and other measures to reduce HIV, TB and KP-related stigma and discrimination in public, private and informal sectors, with a particular focus on the informal sector.

	<ul style="list-style-type: none"> • Develop and disseminate a guide for media practitioners on ethical, rights and evidence-based reporting on HIV, TB, KP and human rights and utilize the guide for training of media. (particularly in view of the sensationalized reporting on the Family Protection Bill and the impact of this reporting on KP-related stigma and discrimination as well as on their safety and security. • Scale up support to MSM and TG led organizations to address increased levels of stigma and discrimination by targeting religious leaders and landlords following the tabling of the Family Protection Bill and ensuing public anti-LGBTI demonstrations and violence. • Undertake research on how stigma and discrimination manifests in humanitarian settings and use the resulting information to ensure that the existing HIV & TB in humanitarian settings coordination framework is supported to co-ordinate programming to address stigma and discrimination and other human rights violations in humanitarian settings. • Support community-based and -led organizations to address HIV, TB and KP- related stigma and discrimination and other human rights violations against refugees and IDPs. Scale up multi-sectoral sensitization and engagement fora for key national, county, community and religious leaders, PLHIV and KPs to address human rights and gender-related barriers to access HIV and TB services in “high stigma” counties.
Ensure non-discriminatory provision of health care	<ul style="list-style-type: none"> • Finalize and integrate HIV and human rights training modules in the pre-service training for all health care workers and build capacity of health care training institution personnel to deliver the pre-service human rights curriculum, including via collaboration with people living with HIV and key population organizations. • Institutionalize regular, in-service refresher training for all health facility staff on HIV, TB, human rights, gender equality (including training related to GBV and SRH) and medical ethics, including on the Kenya National Patients’ Rights Charter. • Produce and implement standardized training curriculum for community health volunteers on HIV, TB, human rights, gender equality (including training related to GBV and SRH and medical ethics and support ongoing training for community health volunteers. • Support implementation of an M&E system to document not only the number of health care workers trained but also the impact of human rights related training on health outcomes, disaggregated based on sex, gender identity and sexual orientation.

	<ul style="list-style-type: none"> Support civil society and key population led organizations to continue and scale up community led monitoring of human rights violations, including violations perpetrated by health care workers towards people living with HIV, TB or malaria, and incorporate findings of such monitoring into training for health care workers and for advocacy purposes.
Ensure rights-based law enforcement practices	<ul style="list-style-type: none"> Develop monitoring and evaluation tools to routinely assess not only the reach and coverage of but also the effectiveness and impact of training disaggregated by sex, gender identity and sexual orientation, and adjust these efforts as necessary. Scale up engagement with stakeholders in law enforcement to strengthen their understanding of HIV, TB, key populations, human rights and gender. Support community led dialogues with sub county security, NGAOs and Nyumba Kumi¹²⁹ to strengthen community-security structures relations. Review and update the Police Service human rights training module to reflect results from latest Stigma Index Assessment and knowledge and attitude assessments conducted under GC6 and integrate into pre-service training curriculum. Develop a human rights training module for the Prisons Service and integrate this module into pre-service training. Undertake a knowledge assessment for county askaris on human rights and gender and rights-based policing to guide the development of an engagement module. Develop and implement a county askari training module on rights- based law enforcement in the context of HIV and TB.
Improve legal literacy	<ul style="list-style-type: none"> Develop monitoring and evaluation tools to routinely assess not only the reach and coverage of but also the effectiveness and impact of legal literacy efforts disaggregated by sex, gender identity and sexual orientation, and adjust these efforts as necessary. Map legal literacy efforts related to HIV, TB, malaria, and key and vulnerable populations undertaken by organizations across Kenya to better coordinate and plan legal literacy activities and to identify opportunities to integrate efforts into HIV, TB and malaria services or programs. Support capacity building of HIV, TB and malaria stakeholders and key and vulnerable population led networks to carry out legal literacy training (including in existing HIV, TB and malaria programs), and provide resources for them to sustain and scale up training of peer educators.

¹²⁹ Nyumba Kumi Initiative is an approach to policing that brings together the police, civil society and local communities to develop local solutions to safety and security concerns.

	<ul style="list-style-type: none"> • Develop user friendly updated legal literacy resources on human rights, access to justice and legal services for people living with HIV, TB, malaria and key and vulnerable populations for use by peer educators. • Support nationwide and county specific legal literacy campaigns designed to increase public awareness of HIV, TB, malaria, key populations, gender equality and human rights. • Translate the HakiPlus App content into multiple languages to make it more accessible to a wider audience. • Consider integrating subject matter on human rights in the context of health in secondary school curricula.
Improve access to justice	<ul style="list-style-type: none"> • Make provision for ongoing training of both paralegals and pro bono lawyers and ensure that paralegals are paid a reasonable stipend and that payment of court fees and ancillary costs are covered by funding to reduce the high turnover of paralegals and pro bono lawyers. • Review the curricula of NASCOP and KRCS for paralegal training and standardize the curriculum for use across the board. • Ensure that IPV survivors are advised by paralegals of their right to have cases of IPV and GBV prosecuted and that ADR only be employed with the specific consent of the IPV survivor, their options having been fully explained to them. Where ADR is employed, ensure that the survivor's right to justice is not compromised. • Ensure that the paralegal training curriculum is clear on the types of cases that are to be taken on by paralegals to address human rights and gender barriers to access to HIV, TB and malaria services. • Consider the provision of psycho-social support, in the form, for example, of opportunities for debriefing sessions as a standard part of paralegal programming. • Ensure that HIV, TB, law and human rights is incorporated into the law school curriculum. • Foster increased collaboration with universities and law clinics to expand the development of educational resources to facilitate better access to the tribunals for KP. • Scale up activities to sensitize members of the judiciary on HIV, TB, human rights and the law. • Strengthen regional engagement with judges across the region for peer to peer learning for members of the judiciary to ensure a broader understanding and commitment to human rights in the context of HIV, TB, and malaria. • Advocate for the amendment of HAPCA to afford HAT the power to enforce its own judgments for damages. Alternatively ensure that provision is made for funding to cover the court and other ancillary costs associated with enforcing the judgment in the High Court.

	<ul style="list-style-type: none"> • Provide support for the provision of psychosocial support to HAT complainants either through the employment of relevant staff at the Tribunal or through the establishment of a formal referral system to existing services. • Develop monitoring and evaluation tools to routinely assess not only the reach and coverage of but also the effectiveness and impact of programming to increase access to justice.
Improving laws and policies relating to HIV and HIV/TB	<ul style="list-style-type: none"> • Conduct a Legal Environment Assessment (LEA) on laws, policies and practices that impact on access to HIV and TB services at both national and county levels on HIV and TB. • Use the results of the LEA to inform targeted engagement with National and County policy makers for reforming laws and policies that impede access to HIV and TB services and exacerbate gender inequality, including those that relate to age of consent to testing and treatment and the task shift policy for HIV counselling and testing. • Ensure both capacity and funding for conducting a rapid analysis of the impact of existing or proposed laws to provide evidence for engaging with lawmakers. • Strengthen mechanisms for strengthen the capacity of community-led organizations and networks to effectively undertake community monitoring of and engagement in legislative processes and developments that impact on communities affected by HIV and TB.
Reduce HIV-related gender discrimination	<ul style="list-style-type: none"> • Strengthen strategic linkages between and accountability of all actors to promote a coordinated response to HIV/GBV/SRH through implementation of the Inter-ministerial commitment plan on ending new HIV infections, GBV and gender inequalities. • Scale up POLICARE facilities and establish safe houses and shelters in all 47 counties that are KP friendly. • Scale up interventions to address GBV against transgender people. • Strengthen County Gender, HIV, GBV and Human Rights Coordinating Committees for improved coordination, referrals and monitoring of GBV cases. • Undertake the validation and digitalization of the GBV reporting tool and use the data to inform programming and monitor 100% linkage to services for GBV survivors and resolution of cases. • Conduct needs assessment of Gender Desks and Child Protection Units and use the results to strengthen both. • Strengthen the capacity of community gatekeepers and opinion leaders to address and raise awareness about harmful social cultural practices that increase vulnerability to

	<p>HIV, TB, SGBV, new HIV infections and adolescent pregnancies.</p> <ul style="list-style-type: none"> • Review the male engagement toolkit to integrate human rights and gender transformative approaches. • Conduct sensitization of national, county and community HIV and TB actors on the national GBV guidelines. • Develop, produce, and distribute behaviour change communication materials on SGBV. • Strengthen linkages between community based and led organizations to strengthen GBV response. • Recruit, capacity build and support GBV champions and paralegals to provide survivor centred support for GBV survivors.
Community mobilization and advocacy for HIV/TB	<ul style="list-style-type: none"> • Strengthen community leadership and engagement in public participation and legislative processes for law and policy reforms relating to TB and HIV. • Develop and implement a community led advocacy strategy and plan. • Ensure that funding gets down to community led organizations to engage in community mobilization and advocacy. • Provide targeted capacity-building initiatives for community-led organizations, focusing on areas such as project management, advocacy strategies, financial management, and organizational development. Strengthening their capacity will enhance their ability to engage in effective community mobilization and advocacy. • Continue and expand support for community-led research and advocacy initiatives. This empowers communities to generate evidence, participate in policy dialogues, and advocate for changes that positively impact their health and well-being.

5.2 Recommendations for Programs to Reduce Barriers to TB Services

The following recommendations are proposed to strengthen programs to reduce human rights-and gender-related barriers to TB services.

Program Area	Recommendations
Eliminate TB-related stigma and discrimination	<ul style="list-style-type: none"> • Ensure that new National Strategic Plan for Tuberculosis, Leprosy and Lung Health, which is currently under development, highlights the implementation of programs to reduce stigma and discrimination related to TB, including internalized stigma, as a strategic intervention to remove legal, gender, and human rights barriers to TB services. • Disseminate and implement the TB workplace policy.

	<ul style="list-style-type: none"> • Provide technical support to CSOs and CLOs to develop and implement TB workplace policies in their own organizations. • Finalize the TB stigma assessment and use the findings to develop a TB stigma reduction plan. • Develop and implement a communication plan on TB stigma, its impact, and available services. • Conduct awareness and advocacy campaigns for TB stigma reduction in communities, prisons, humanitarian settings, police holding cells, and workplaces. • Develop and implement an improved M&E system that looks at the impact as well as outputs of stigma and discrimination reduction interventions. • Strengthen coordination and structures for TB related human rights reporting at the national and county levels. • Develop and implement a costed community rights and gender operational plan at national and county levels. • Ensure the meaningful participation of KP in the design and implementation of stigma and discrimination reduction programs. • Request technical support from UN agencies and development partners on TB HRG issues particularly in operationalization of policies and assessments.
Ensure people-centered and rights-based TB services at health facilities	<ul style="list-style-type: none"> • Finalize and integrate TB, HIV and human rights training modules in the pre-service training for all health care workers and build capacity of health care training institution personnel to deliver the pre-service human rights curriculum, including via collaboration with people living with HIV and key population organizations. • Institutionalize regular, in-service refresher training for all health facility staff on HIV, TB, human rights, gender equality (including training related to GBV and SRH) and medical ethics, including on the Kenya National Patients' Rights Charter. • Produce and implement standardized training curriculum for community health volunteers on HIV, TB, human rights, gender equality (including training related to GBV and SRH and medical ethics and support ongoing training for community health volunteers. • Strengthen linkages between private health facilities and established community structures to facilitate stigma and discrimination reduction in private health facilities. • Support implementation of an M&E system to document not only the coverage but also the impact of human rights related training on health outcomes, disaggregated based on sex, gender identity and sexual orientation.

<p>Ensuring rights-based law enforcement practices for TB</p>	<ul style="list-style-type: none"> • Develop monitoring and evaluation tools to routinely assess not only the reach and coverage of but also the effectiveness and impact of training disaggregated by sex, gender identity and sexual orientation, and adjust these efforts as necessary. • Scale up engagement with stakeholders in law enforcement to strengthen their understanding of HIV, TB, key populations, human rights and gender. • Support community led dialogues with sub county security, NGAOs and Nyumba Kumi to strengthen community-security structures relations. • Review and update the Police Service human rights training module to reflect results from the TB stigma assessment (once it is completed) and knowledge and attitude assessments conducted under GC6. • Develop a human rights training module for the Prisons Service and integrate this module into pre-service training.
<p>Improve legal literacy</p>	<ul style="list-style-type: none"> • Map legal literacy efforts related to HIV, TB, malaria, and key and vulnerable populations undertaken by organizations across Kenya to better coordinate, plan and integrate legal literacy activities. • Review legal literacy materials currently being used to ensure that where TB has been integrated into HIV legal literacy materials, that TB has indeed been fully integrated. • Support capacity building of HIV, TB and malaria stakeholders and key and vulnerable population led networks to carry out legal literacy training (including in existing HIV, TB and malaria programs), and provide resources for them to sustain and scale up training of peer educators. • Map key and vulnerable populations for TB and develop user friendly, updated and targeted legal literacy resources on human rights, access to justice and legal services for people living with HIV, TB, malaria and key and vulnerable populations for use by peer educators. • Consider integrating subject matter on human rights in the context of health in secondary school curricula. • Ensure all TB legal literacy efforts include information about the 2018 Tuberculosis Isolation Policy and potential legal recourse for non-compliance, and target county health management stakeholders with training that includes information about the Policy. • Support nationwide and county specific legal literacy campaigns designed to increase public awareness of HIV, TB, malaria, key populations, gender equality and human rights. • Develop monitoring and evaluation tools to routinely assess coverage and impact of legal literacy efforts disaggregated

	by sex, gender identity and sexual orientation, and adjust these efforts as necessary.
Increase access to justice	<ul style="list-style-type: none"> • Make provision for ongoing training of both paralegals and pro bono lawyers and ensure that paralegals are paid a reasonable stipend and that payment of ancillary costs are covered by funding to reduce the high turnover of paralegals and pro bono lawyers. • Review the curricula of NASCOP and KRCS for paralegal training, standardize the curriculum for use across the board and ensure that the training adequately covers TB-related human rights and rights violations. • Scale up activities to sensitize members of the judiciary on TB, human rights and the law. • Consider establishment of key and vulnerable population-run hotlines to provide legal information and referrals in response to TB-related rights violations.
Improve laws, regulations and policies relating to TB	<ul style="list-style-type: none"> • Scale up sensitization of county government, health stakeholders, and key and vulnerable population stakeholders on TB, human rights and the law, including the 2018 Tuberculosis Isolation Policy. • Support and enhance the capacity of civil society organizations and TB stakeholders, particularly those representing key and affected populations, to engage in law and policy monitoring and reform related to TB, particularly at county level.
Reduce TB-related gender discrimination	<ul style="list-style-type: none"> • Ensure that the TB CRG assessment is finalized and the results used to establish baselines and to inform programming. • Consider developing a costed operational plan for CRG interventions at national and county levels. • Ensure that the new National Strategic Plan for Tuberculosis, Leprosy and Lung Health recognizes the need to mitigate harmful gender norms that are barriers to accessing TB services. • Support the scale up of gender sensitive and gender transformative programs to reduce vulnerability to TB and ensure access to TB services. • Support the provision of technical assistance on the design of programs to reduce human rights and gender related barriers to TB services.
Support community mobilization and advocacy	<ul style="list-style-type: none"> • Continue support for and increase membership of national network of TB champions and people affected by TB and support opportunities to routinely convene the network. • Ensure the inclusion of KP, especially men who have sex with men and male sex workers, as TB champions. • Support civil society and key population led organizations to continue and scale up community led monitoring of human

	<p>rights violations, including violations perpetrated by health care workers towards people with TB, and incorporate findings of such monitoring into training for health care workers and for advocacy purposes.</p> <ul style="list-style-type: none"> • Support more community led organizations to conduct CLM using one common CLM tool. • Ensure collation of CLM data to ensure that data can be used for more efficient programming for advocacy for law and policy reform
Address needs of people in prisons and other closed settings	<ul style="list-style-type: none"> • Ensure that training materials on TB and human rights in prisons are integrated into Prison Service pre- service and in-service training. • Facilitate the establishment of psychosocial support groups to address internalized stigma among prisoners with TB. • Develop materials and deliver legal literacy training for prisoners to act as peer human rights educators in prison. • Support advocacy for the implementation of non-custodial sentencing to relieve overcrowding in prisons.

5.3 Recommendations for Programs to Reduce Barriers to Malaria Services

The following recommendations are proposed to strengthen programs to reduce human rights-and gender-related barriers to malaria services.

Program Area	Recommendations
Reducing gender related discrimination and harmful gender norms	<ul style="list-style-type: none"> • Disseminate findings of the matchbox assessment to key stakeholders and utilize the findings of the matchbox assessment to inform the content of the new National Malaria Strategy. • Strengthen health management information system by routinely collecting sex and age disaggregated data on malaria and analyzing results to enhance gender responsiveness of malaria programming. • Support community education on gender equality and patients' rights to be delivered alongside malaria social and behavioral change campaigns, with messages targeted at different groups including mothers, pregnant women, men, fathers, adolescents, community leaders, religious leaders, refugees and schoolchildren. In addition to focusing on identification of malaria symptoms, prevention and timely health seeking behaviors, campaigns could integrate information on more equitable household decision making, the sharing of caregiving activities, the need for men to support their partners to seek care in a timely manner without permission, and challenging harmful gender norms. • Strengthen the capacity of key malaria stakeholders, managers and data analysts to understand, analyze,

	<p>prioritize, and use gender related information, including in future Kenya Malaria Strategy.</p> <ul style="list-style-type: none"> • Strengthen the capacity of key malaria stakeholders and implementors on HRG at all levels of programme design, implementation and evaluation.
Promoting meaningful engagement of affected populations	<ul style="list-style-type: none"> • Scale up and deliver training for all malaria civil society organizations identified via the mapping exercise, and in particular those that represent or are led by affected communities, to enhance their capacity to participate in policy design and monitoring of implementation. • Support the strengthening of community centered elements of the malaria response, such as county and regional networks of malaria civil society organizations, to engage in advocacy efforts at the county and national level. • Sensitize malaria duty bearers, including authorities within the Ministry of Health and the National Malaria Control Program, on the importance of community engagement, particularly by affected communities. • Identify civil society malaria stakeholders to join the Joint HIV, TB and Malaria HRG TWG. • Disseminate the key findings of the Malaria Matchbox Assessment to the broader public via a social media campaign, developed in collaboration with KeNAAM and malaria civil society organizations, and collaboratively develop a plan to respond to and address key findings.
Strengthening community systems for participation in malaria programs	<ul style="list-style-type: none"> • Review existing training curricula for community health volunteers to ensure inclusion of malaria related gender and human rights concerns and support training of community health volunteers to understand human rights and gender barriers to malaria services. • Continue 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. • Expand iMonitor to enable community monitoring of malaria service delivery and train community health volunteers and malaria civil society organizations in use of this tool.
Monitoring and reforming laws, policies and practices	<ul style="list-style-type: none"> • Continue 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.
Improving access to services for underserved populations	<ul style="list-style-type: none"> • Disseminate key findings of the Malaria Matchbox Assessment related to underserved populations to key stakeholders, including the Ministry of Health, the National Malaria Control Program, the human rights and gender technical working group on HIV, TB and malaria, and malaria program implementers in refugee settlements to better understand key areas for improvement to remove existing human rights related barriers to access services.

	<ul style="list-style-type: none"> • Engage with implementers operating in the refugee camps to map who and what services are being offered by partners working on behalf of UNHCR and related agencies. • Revise the policy on free bed net distribution to ensure that they reach underserved populations such as truckers, informal traders, fisherfolk and others. • Engage with the Federation of Kenya Employers and with trade unions to ensure that employees are able to access malaria testing and treatment without losing income and also to ensure that seasonal workers are accommodated in accommodation that permits the hanging of individual bed nets. • Engage with the Ministry of Education to ensure that students at boarding schools are similarly accommodated in dormitories that allow the hanging of individual bed nets and also to ensure that teachers and matrons are trained to recognize early symptoms of malaria. • Consider the development of a phone app, similar to that used by the KRCS for HIV and TB, to provide easily accessible information on malaria and where to obtain testing and treatment. Alternatively integrate malaria information into the existing app. • Increase legal literacy for underserved communities to know their rights and support them to mobilize and hold duty bearers accountable. This includes engaging humanitarian stakeholders to ensure the refugee populations (and other affected by emergencies) are provided with tools and information to understand their health-related rights, including in the context for malaria.
--	--

Annex 1: Summary of Methods

The assessment was conducted between May and September 2023 following a methodology developed by the Global Fund. Assessment team members included a lead researcher and one national consultant. The steps used to conduct the assessment were the following:

- **Document review**--An extensive review document was completed (May-June 2023). Sources included Global Fund grant documents (grant agreements, budgets, Progress Update and Disbursement Request submissions, implementation letters, and grant performance reports); implementer grant agreements and reports (monthly, quarterly, semesterly and annual financial and programmatic reports); program outputs (activity reports, tools, training manuals, guidelines, policies, etc.); documentation on human rights related barriers (violations reports, press statements, etc.); national plans and strategies for HIV and TB; and other documents and sources related to progress to reduce or remove human rights and gender barriers
- **Data abstraction**--Data was abstracted from routine grant accountability reports (M&E data), community-led monitoring, and community monitoring reports of human rights violations. Financial data was abstracted from routine grant accountability reports, including progress reports and budget documents.
- **Key informant interviews and group discussions**--Key informant interviews (using interview guides) were conducted with 25 stakeholder representatives (May-July 2023). Group discussions were conducted with representatives of key populations (sex workers, people who use or inject drugs [PWUID], gay men and other men who have sex with men [MSM], transgender people, and others participating in or benefitting from programs to reduce barriers.
- **Site visits**-- Site visits were conducted (June and July 2023) to HAPA Kenya & Reach Out Centre Trust in Mombasa county, Amkeni in Kilifi, Trans Alliance in Kisumu, and CAMDA and KANCO in Kakamega/ Bungoma. Sites were selected to represent some of the diversity of settings where programs to reduce barriers are currently implemented as well as where there were opportunities to see synergies between the different programs, implementers and other stakeholders.
- **Stakeholder validation**--Final review and validation of the assessment report, including the scorecard results, is pending.

To generate the scorecard results, the following definitions were applied:

Rating	Definition
0	No formal programs or activities identified.
1.0	One-off activities that are time-limited, pilot initiative.
2.0	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching <35% of targeted population.
2.3	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching 35-65% of targeted population.
2.6	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching >65% of targeted population.
3.0	Operating at subnational level (btw 20% to 50% national scale) and reaching <35% of targeted population
3.3	Operating at subnational level (btw 20% to 50% national scale) and reaching 35-65% of targeted population
3.6	Operating at subnational level (btw 20% to 50% national scale) and reaching >65% of targeted population
4.0	Operating at national level (>50% of national scale) and reaching <35% of targeted population
4.3	Operating at national level (>50% of national scale) and reaching 35-65% of targeted population
4.6	Operating at national level (>50% of national scale) and reaching >65% of targeted population
5	At scale is defined as more than 90% of national scale, where relevant, and more than 90% of the population
Program is assessed to have achieved the goal when there is impact on service continuum	
Goal	<p>Impact on services continuum is defined as:</p> <ul style="list-style-type: none"> a) Human rights programs at scale for all populations; and b) Plausible causal links between programs, reduced barriers to services and increased access to HIV/TB services.

Annex 2: List of Documents Reviewed

The following types of documents were used sources for the assessment:

Global Fund materials

GC6 application materials (funding request forms, detailed budgets, performance frameworks)

Progress Updates (for PRs 1, 2 and 3)

SR financial and narrative reports

Global Fund Technical Guidance Briefs

National documents

National Strategic Plans for HIV, TB and malaria

Program Review reports for HIV, TB and malaria

Other relevant policies, plans and strategies

Legal Environment and CRG Assessments

Materials from implementers

Training materials

Training reports

Reports for community dialogues, community engagement events, etc.

Reports and data on human rights violations (KRCS for example)

Meeting reports

Journal articles

Relevant articles from peer reviewed journals

Annex 3: List of Stakeholders

Representatives from the following stakeholders participated in the progress assessment:

AMKENI Malindi
AMREF
BHESP
CABDA
HAPA Kenya
KANCO
KELIN
KeNAAM
KENPUD
KP Consortium
KRCS
NASCOP
National Malaria Control Programme
National Police Service (AIDS Control Unit)
National Prisons Service
National Treasury
National Tuberculosis, Leprosy and Lung Disease Programme
NEPHAK
NextGen Lawyers
NSDCC
President's Malaria Initiative
Reach Out Centre Trust
Stop TB Kenya
Trans Alliance
UNAIDS