



MINISTRY OF HEALTH

POLICY ANALYSIS AND ADVOCACY DECISION MODEL FOR SERVICES FOR KEY POPULATIONS IN KENYA

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CONTENTS

Contents.....	iii
Acknowledgments.....	iv
Executive Summary.....	v
Abbreviations.....	xiv
Assessment Findings: Framework.....	1
1. Coordination and Integration	1
2. Data-informed Planning and Budgeting	2
Assessment Findings: Community Partnership	4
3. Community Engagement and Participation	4
Assessment Findings: Legal Environment.....	5
4. Authorization	5
5. Privacy and Confidentiality	8
6. Registries	9
7. Stigma and Discrimination	10
8. Criminal and Administrative Law: Criminalization and Punishment	11
9. Gender-based Violence	14
10. Torture and Cruel, Inhuman, or Degrading Treatment or Punishment	15
11. Monitoring and Enforcement of Legal and Human Rights	16
Assessment Findings: Intervention Design, Access, and Implementation.....	18
12. Procurement and Supply Management.....	18
13. Overarching Services Design.....	19
14. HIV Counseling and Testing.....	20
15. Antiretroviral Treatment.....	21
16. Tuberculosis Services.....	22
17. Hepatitis Services	23
18. Opiates Substitution Therapy	23
19. Needle and Syringe Programs	24
20. Condoms and Lubricants	25
21. Sexually Transmitted Infections.....	26
22. HIV Prevention Outreach.....	27
23. Information, Education, and Communication.....	28
24. Alcohol and Substance Abuse Harm Reduction	28
25. Sexual and Reproductive Health and Rights.....	29
Conclusion.....	31
References.....	32
Appendix: Summary of Stakeholders' Review of Assessment Findings.....	41
Findings and Recommendations on Kenya's Policy Framework.....	41
Findings and Recommendations on Community Partnership	42
Findings and Recommendations on Authorization	43
Findings and Recommendations on Informed Consent.....	44
Findings and Recommendations on Privacy And Confidentiality	45
Findings and Recommendations on Registries.....	45
Findings and Recommendations on Stigma And Discrimination.....	46
Findings and Recommendations on Criminalization	47
Findings and Recommendations on Gender-based Violence.....	48
Findings and Recommendations on Torture and Cruel, Inhuman, and Degrading Treatment or Punishment.....	48
Findings and Recommendations on Human Rights	49
Findings and Recommendations on Procurement and Supply Management.....	49
Finding and Recommendations on Interventions	50

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EXECUTIVE SUMMARY

Introduction

Kenya has witnessed a steady decline in HIV prevalence over the years: from 7.2 percent among those 15 and older in 2007 to 5.6 percent for this cohort in 2012 (National AIDS & STI Control Programme, 2013). Although the epidemic is generalized, it is concentrated in key populations, which in 2006 together accounted for 33 percent of new infections (Gelmon L, Kenya P, F. Ogunya, et al., 2009, p.iv). Of these new infections, sex workers and their clients contributed 14 percent, men who have sex with men and prison populations contributed 15 percent, and people who inject drugs contributed 3.8 percent.

In April 2013, the National AIDS Control Council invited the Health Policy Project/Kenya to join other partners in supporting the development of a key populations policy—the fourth Kenya National AIDS Strategic Plan (Kenya AIDS Strategic Framework 2014/15–2018/19)—and other HIV policy-oriented initiatives. We provided technical assistance to conduct an assessment of current policies and identify actions and recommendations to inform the new plan.

Methodology

From 2010–2012, the global Health Policy Project (funded by the United States Agency for International Development), in partnership with African Men for Sexual Health and Rights (AMSHeR), developed *Policy Analysis and Advocacy Decision Model for HIV-Related Services: Males Who Have Sex with Males, Transgender People, and Sex Workers* (Beardsley K., 2013), hereafter referred to as the Decision Model. It provides country stakeholders—such as advocates, policymakers, and service providers—with tools to inventory, assess, and advocate policies that govern the accessibility and sustainability of services for key populations. By comparing these policies to global normative guidelines and best practices, the model reveals gaps in and challenges to implementation.

Using the model, the study team analyzed 120 policy and program documents related to HIV and/or key populations. The team also conducted three stakeholder meetings to assess the impact of existing policies on key populations in Kenya.

Key Findings and Recommendations

Framework coordination and integration

Governments have an obligation to provide an effective coordination framework to ensure the full realization of the right to health. Such a framework should integrate program responsibilities across government departments and enable information and knowledge sharing. Several documents reflect this global consensus: International Center for Research on Women, Government of Kenya, Global Coalition on Women and AIDS, July 2009; Office of the United Nations High Commissioner for Human Rights and Joint United Nations Programme on HIV/AIDS, 2006, p. 63; and World Health Organization, 2000.

This review found poor integration and coordination among the sectors with which key populations interact. For example, the MOH leads Kenya's response to HIV and AIDS and police departments are responsible for law enforcement, but the two units lack clear integration and coordination for meeting the HIV-related needs of people charged with criminalized behavior.

Recommendation: Policies should provide for the coordination and integration of HIV and AIDs services for key populations in Kenya. Special attention should be paid to integrating health outcomes in law enforcement strategies and coordinating law enforcement with related health programs. This will increase entry by key populations to HIV care and treatment, improving adherence to treatment regimens and thus to health outcomes.

Data-informed planning and budgeting

Effective health planning requires regional and local data on the true burden of HIV among key populations (Joint United Nations Programme on HIV and AIDS/World Health Organization, 2003).

In general, epidemiological surveillance of these groups around the world is inadequate. In Kenya, interventions are hampered by a paucity of data on the characteristics, sexual behavior, and even the size of key populations. Moreover, although policy documents identify the needs of sex workers and people who inject drugs for services, similar documents for men who have sex with men or for transgender people do not exist.

Recommendation: Kenya should adopt and implement the World Health Organization's guidelines on estimating the size of populations most at risk for acquiring HIV. These estimates should inform the development and funding of services dealing with HIV and sexually transmitted infections and guidelines to implement these services for key populations.

Community engagement and participation

Development of effective programs or policies requires the involvement and support of the people they are attempting to serve (World Health Organization, 2006, pp.15-16).

Although Kenya's Constitution requires public participation in decision making, this assessment found general policy silence regarding the full involvement of key populations in decision-making processes. These populations lack opportunities and platforms to influence policies that affect them and to advocate improved availability and quality of services. Organizations representing these groups have been denied registration on the grounds that they contravene "public order" or "public morals." For example, the National Gay and Lesbian Human Rights Commission was refused registration because Kenya's penal code criminalizes homosexuality.

Recommendation: Key populations should be enabled to participate effectively in developing and deciding on policies related to their health, including those governing HIV and AIDS services. This will promote dialogue between the government and key populations even though Kenya's penal code criminalizes some behaviors of those populations.

Legal environment

Authorization for services

States have a duty to provide comprehensive and inclusive services to impact AIDS responses (Office of the United Nations High Commissioner for Human Rights and Joint United Nations Programme on HIV/AIDS, 2006).

Current policies and the Kenya Prisons Act (Government of Kenya, 2012 [1977]) give public health officials responsibility for HIV prevention programs and other services for inmates. However, no policy supports access by prison inmates and other detainees to services related to HIV, sexually transmitted infections, and sexual and reproductive health. Moreover, although the current strategic plan for HIV and AIDS (National AIDS Control Council, 2009) provides HIV prevention services for key populations in detention and community settings, other policies and program guidelines exclude services to criminalized groups. As a result, HIV and AIDS services for people in detention settings are limited to information and treatment for those living with the disease.

Recommendation: Policy should explicitly authorize health services and HIV prevention, treatment, and care, including the provision of prevention commodities to people in detention, juvenile detention, and prison settings.

Consent

Informed consent is required for people to be given HIV treatment and services, such as counseling and testing. Informed consent is also required for people to participate in research (United Nations

Office on Drugs and Crime and Canadian HIV/AIDS Legal Network, 2010, p. 186); World Health Organization, 1994, p.11).

Kenyans may not receive HIV treatment and services such as counseling and testing without their informed consent. However, prisoners are exempt from this safeguard if prison authorities consider treatment to be lifesaving or in the best interests of other prisoners. Moreover, members of key populations may be withdrawn from participation in biomedical research studies without their consent, because they have been arrested or incarcerated on grounds of their criminalized behavior. This risk potentially places their health in jeopardy, and Kenyan research policies are silent about it.

Recommendation: Policies should provide clear guidelines on the continuum of care if sex workers, people who inject drugs, transgender people, or men who have sex with men are withdrawn from experimental treatment—especially biomedical treatment—because of arrests arising from their criminalized status.

Privacy and confidentiality

Public health legislation should ensure that information related to the HIV status of an individual is protected from unauthorized collection, use or disclosure in the healthcare and other settings, and that the use of HIV-related information requires informed consent. (Joint United Nations Programme on HIV/AIDS, 1999, p. 122)

While policies in Kenya provide for the privacy and confidentiality of personal medical and drug-dependence treatment and data on the use of these services, other policies—particularly those relating to criminal justice and administration of justice—ignore the right of key populations to privacy and confidentiality. An example is the Evidence Act, which fails to mention discovery and admissibility of medical, mental health, and drug-dependence treatment records. It is also silent on treatment for drug dependence.

Recommendation: Clear policy statements are needed that forbid abuse of the right of people with criminalized behavior to privacy and confidentiality of their medical data. Policies should also remove provisions that limit protection of human rights to circumstances that only fall within existing laws, because this excludes criminalized populations.

Registries

Public data collection and management systems should protect personal data and eradicate discriminatory actions or disclosure that can affect access to services by key populations (Office of the United Nations High Commissioner for Human Rights and Joint United Nations Programme on HIV/AIDS, 2006, p. 27; American Bar Association Rule of Law Initiative, 2011, p. 65).

Kenya has several policies and laws that guide the collection and storage of data regarding infectious diseases, including HIV and other sexually transmitted infections and tuberculosis. The National Drug Control Authority is authorized to collect and manage data on drug use. Kenya also maintains a register of dangerous sexual offenders, which is open to examination by “any person who has a reasonable cause to so examine it” (Government of Kenya, 2006, p. Pt 39[13]). This register is potentially problematic for men who have sex with men and sex workers. Although these groups are not listed on the register, because they are not categorized as dangerous sexual offenders, the official register could encourage police to maintain unofficial lists of people they suspect practice criminalized sexual behavior.

Recommendation: Policy on disease surveillance in Kenya should address hepatitis among key populations: in particular, people who inject drugs and men who have sex with men. Additionally, policies regulating the Sexual Offences Register should explicitly prohibit the creation or use of unofficial lists by law enforcement officers and nonstate actors based on profiling of men who have sex with men and sex workers.

Stigma and discrimination

Stigma and discrimination can deter key populations from accessing HIV services and information. Religious and customary beliefs and laws also create a highly stigmatized environment for key populations.

States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV and people with disabilities from discrimination in both the public and private sectors. (Office of the United Nations High Commissioner for Human Rights and Joint United Nations Programme on HIV/AIDS, 2006, pp. 17-18)

Although strong policies exist that prohibit discrimination and guarantee equal rights for people living with and affected by HIV, none specifically mentions sexual orientation, gender identity, or sex work. While policies such as the National Guidelines for HIV/STI Programs for Sex Workers require health workers to avoid judgmental and stigmatizing attitudes, stigma and discrimination still abound.

Recommendation: Policies should replicate the nondiscrimination language provided in the standards for treatment and rehabilitation of people with substance use disorders:

Treatment facilities seek to ensure that no discrimination occurs on the basis of race, class, gender, ethnicity, colour, age, location, social status, language, sexual orientation, diagnosis, disability, clinical or forensic status in the quality of care and the type of service offered. (National Authority for the Campaign against Alcohol and Drug Abuse, 2010, pg. 14)

Criminalization

Criminalization prevents access to services and perpetuates stigma and discrimination against sex workers and men who have sex with men (Beyrer C., S. Baral, 2011; Global Network of Sex Work Projects, 2011, p.76).

Homosexual behavior and living off the earnings of sex work are outlawed in Kenya. Sex work is also criminalized by laws against solicitation, loitering with intent, and disorderly behavior. The Narcotic Drugs and Psychotropic Substances (Control) Act facilitates harm-reduction interventions and medically-assisted therapy for people who inject drugs. However, gaps in the narcotics law may still be used to harass anyone living with and supporting people who inject drugs. The current policies also do not contain clear statements on the conditions under which sex workers, men who have sex with men, and people who inject drugs can seek services without legal reprisal.

Recommendation: Policy should give clear guidance on access by key populations to health services that are nonstigmatizing and nondiscriminatory, even in the context of existing criminalization. Policy must clearly state conditions under which key populations can seek health services without fear of legal reprisal.

Gender-based violence

Gender-based violence refers to violence that targets individuals or groups on the basis of their gender. This includes acts that inflict physical, mental, or sexual harm or suffering, the threat of such acts, coercion, and other deprivations of liberty (United Nations General Assembly, 1993).

Policies in Kenya allow zero tolerance for sexual harassment, abuse, and exploitation. However, populations with criminalized behaviors, such as men who have sex with men, sex workers, and transgender people, are more likely than others to experience harm in detention and prison settings, where they are vulnerable to sexual abuse.

Recommendation. Policy should clearly provide comprehensive protection against gender-based violence and sexual violence regardless of sexual status, and provide special protection from sexual violence to key populations in prisons.

Monitoring and enforcing human legal rights and protection from torture and cruel, inhuman, or degrading treatment or punishment

International human rights bodies, particularly the United Nations Committee on Human Rights, have repeatedly affirmed that the degradation and abuse of a person based on their actual or perceived sexual orientation or gender identity violates international conventions related to human rights, including the Universal Declaration of Human Rights. (United Nations Office of the High Commissioner for Human Rights, 2011, p. 6)

Kenya has ratified major international conventions related to human rights, and the Constitution guarantees rights for all citizens: for example, the United Nations International Covenant on Civil and Political Rights (1966), the United Nations International Covenant on Economic, Social and Cultural Rights (1966), and the United Nations Convention on the Elimination of All Forms of Discrimination against Women (1979).

However, members of key populations are disproportionately subjected to sexual violence and cruel, inhuman, or degrading punishment for transgression of gender roles. Some of Kenya's laws also infringe on the rights of key populations. For instance, immigration laws bar entry to anyone ever convicted of a crime carrying a prison sentence of more than three years or whose conduct can offend public morality. And although the civil registration laws do not specifically define gender as "male" and "female," they pose a problem for transgender people, because they do not offer guidance on how gender can be changed on someone's registration papers.

Recommendation: Kenya should enact the Legal Aid Bill and educate key populations on its provisions, including guidance on how to access the legal aid fund in civil and criminal proceedings and constitutional matters.

Intervention design, access, and implementation

Procurement and supply management

Stock-outs of essential commodities and medications can be major barriers for key populations accessing HIV services. International best practices suggest that adequate laws, policies, and guidelines should be in place to ensure proper management of the procurement process (JSI/Deliver, 2005, p. 29).

The assessment found that although Kenya has laws, policies, and guidelines to ensure better management of HIV-related commodities and medical supplies, none provides participation by key population groups in product selection or other decisions. In addition, although medically-assisted therapy is recognized as a key intervention for people who inject drugs, no guideline provides funding for the procurement and distribution of the drugs used.

Recommendation: Policy should ensure comprehensive and consistent procurement, supply, and distribution of HIV commodities, including needle and syringe program kits, condoms, and lubricants as part of the Essential Drugs List. The public should also be economically empowered to pay an incrementally increasing share of their HIV prevention- and treatment-related costs.

Integration of services

Integration of services and referral systems can expand entry into healthcare and related services for key populations (Joint United Nations Programme on HIV/AIDS, 2009, pp. 10-11).

Policies in Kenya emphasize integrating services for HIV and other sexually transmitted infections and sexual and reproductive health but do not offer practical guidelines on how to do this. Moreover, policies are silent on the needs of people who inject drugs, sex workers, men who have sex with men, and transgender people, and therefore cannot guarantee that these populations will receive high-quality services that are sensitive to their needs. The National Guidelines for HIV Testing and Counselling in Kenya (National AIDS and STI Control Programme and Ministry of Public Health and

Sanitation, 2010b, p. 8) notes that services for key populations are best provided in stand-alone settings, which are more expensive to run and rarely funded by the government, posing challenges for their sustainability.

Recommendation: Policy should provide clear guidelines on integrating services and referrals specifically for people who inject drugs, men who have sex with men, transgender people, and sex workers.

HIV counseling and testing

Effective HIV counseling and testing requires nonjudgmental support and high-quality services specifically designed to address the needs of MSM, TG, and SWs (AVAC, 2011, p. 11).

Kenya's policies do not identify mechanisms to involve men who have sex with men, transgender people, and sex workers in the development of HIV counseling and testing protocols or in monitoring and evaluation of HIV counseling and testing services—even though they identify men who have sex with men and sex workers as vulnerable groups who should receive these services.

Recommendation: Policy should facilitate the engagement of key populations in the development and implementation of HIV counseling and testing protocols, as well as monitoring and evaluating HIV counseling and testing programs.

Antiretroviral treatment

The promotion of a legal and social environment that protects human rights and ensures access to prevention, treatment, care, and support without discrimination or criminalization is essential for achieving an effective response to the HIV epidemic and promoting public health (World Health Organization, 2011, p. 24).

Treatment interruption is a significant risk among key populations owing to frequent arrests by the police or violence by nonstate actors. The policy guiding the management of antiretroviral therapy in Kenya does not guarantee that antiretrovirals will be provided free of charge to anyone in Kenya, including men who have sex with men, people who inject drugs, transgender people, and sex workers. As a result, the costs associated with antiretroviral therapy services—such as CD4 count testing, provider fees, and medications for opportunistic infections—make adherence to treatment especially hard for key populations. Although Kenya's policy on antiretroviral therapy does mention that key populations have trouble accessing services, the only remedies it proposes are additional mobilization strategies and prevention education. It says nothing about how the treatment challenges are to be addressed.

Recommendation: Policy should describe mechanisms to ensure a continuum of care so that people in detention settings can maintain their adherence to antiretroviral therapy.

Opiates substitution therapy

Because of the chronic relapses associated with drug dependence and the need to address social and psychological dimensions, achieving abstinence is often a lengthy and difficult process for many people. The provision of “stepping stones” or “stabilizing strategies” in the form of short-term and more achievable goals helps to define and structure progress and also to reduce drug-related harms (World Health Organization, 2006).

Although policies in Kenya allow for medically-assisted therapy for people who inject drugs, they do not address funding for the drugs used or how long-term therapy will be sustained. Thus, while policy says that medically-assisted therapy should be affordable and preferably free, no guidelines say how this should be done.

Recommendation: Policy should ensure state funding for opiates substitution therapy programs to sustain existing programs and support their scale-up.

Needle and syringe programs

Collaboration among governments, nongovernmental organizations, parents, teachers, health professionals, youth and community organizations, employers' organizations, workers' organizations, and the private sector is essential to the success of strategies to reduce demand for drugs and also to reduce harm. It improves public awareness and enhances the capacity of communities to deal with the negative consequences of drug abuse. Public responsibility and awareness and community mobilization are of paramount importance in ensuring the sustainability of demand reduction strategies (United Nations General Assembly, 1998).

Kenya's needle and syringe programs are guided mainly by the *Standard Operating Procedure for Needle and Syringe Exchange Programmes for People Who Inject Drugs* (National AIDS and STI Control Programme and Ministry of Public Health and Sanitation, 2013c) and the *Narcotic Drugs and Psychotropic Substances (Control) Act, No. 4 of 1994* (GOK, 2012 [1994]). Policies provide for nationwide coordination and funding of the Needle and Syringe Exchange Programme (NSEP), including provision of stock and collection and disposal of used sharps. However, policies only allow for NSEP outlets that have been authorized by the Ministry of Health, and which are most likely fixed facilities or pharmacies; any other facilities offering needle and syringe exchange services risk contravening the law.

Recommendation: Policy should provide for the engagement of law enforcement officers in harm reduction and drug dependence treatment programs.

Sexually transmitted infections

Health systems should take into account the need to integrate services for HIV and other sexually transmitted infections into other health services, in order to ensure total and complete "health for all" (World Health Organization, 2011, p. 20).

Kenya's policies on treatment and management of sexually transmitted infections generally follow international best practices. The national guidelines on reproductive tract infections have adopted the evidence-based syndromic approach to diagnosis and treatment. Although the guidelines allow presumptive treatment for adults and children, they do not offer any guidance on whether pharmacists and other non-facility-based health services can offer it.

Policy documents govern the management of sexually transmitted infections for sex workers but not for men who have sex with men and transgender people. However, efforts are under way by the National AIDS and STI Control Programme to draft comprehensive guidelines for services related to HIV and other sexually transmitted infections addressed to key populations, and to provide them free of charge. The draft policy also provides for contact tracing and presumptive treatment for sexual partners. These provisions will need to be integrated into other policies and guidelines to ensure effective implementation.

Recommendation: The Kenya Health Policy, which is the main policy document for the health sector, should provide for a coordination and integration mechanism with policies specific to key populations.

Condoms and lubrication

Consistent and correct use of condoms and water-based lubricants is strongly associated with a reduction in the risk of HIV transmission among men who have sex with men and sex workers (WHO, 2011, p. 33).

The national AIDS strategic plan supports the provision of these commodities to sex workers and men who have sex with men. Some policy documents also say that lubricants should be part of the essential package of commodities for sex workers. The assessment showed that development partners,

not the government, have been procuring and distributing lubricants. As a result, frequent stock-outs have occurred when partner funding is not available.

Recommendation: Condoms and condom-compatible lubricants should be on Kenya's essential drugs list. Policy should provide for a funding and distribution mechanism to avoid constant stock-outs.

Information, education, and communication

These activities raise awareness of HIV and provide information about methods of prevention, behavior change, and treatment. Involving community members in designing and delivering information, education, and communication activities and materials ensures their effectiveness (World Health Organization, 2011, p. 24).

The National AIDS & STI Control Programme is developing standardized information, education, and communication materials for key populations. Unfortunately, no policies provide funding for publication and distribution. As a result, the availability of these materials is contingent on the availability of funding from donors.

Recommendation: Policy should ensure that information, education, and communication materials that specifically address HIV and AIDS prevention, treatment, and care among key populations are freely available in venues accessible by these populations. Policy should also protect key populations from harassment for possession of these materials.

Outreach

By increasing access to HIV interventions, outreach activities also increase the interventions' impact. They are often the best way to reach hidden or hard-to-reach populations (United Nations Development Programme, 2009; Joint United Nations Programme on HIV/AIDS, 2011).

In Kenya, outreach is an essential element of the service guidelines for sex workers and people who inject drugs. Because there are no service guidelines for men who have sex with men and transgender people, an outreach policy for them does not exist.

Recommendation: Clear policy guidelines on outreach are needed that specifically address the needs of men who have sex with men, people who inject drugs, transgender people, and sex workers. The community health strategy should address the health promotion, prevention, curative, and rehabilitative needs of key populations.

Alcohol and substance abuse harm reduction

Access to alcohol and substance abuse harm-reduction programs for key populations is essential to HIV prevention efforts (World Health Organization, United Nations Office on Drugs and Crime, and Joint United Nations Programme on HIV/AIDS, 2012 [2009], p. 11).

The National Standards for Treatment and Rehabilitation of Persons with Substance Use Disorders (National Campaign against Drug Abuse Authority, 2010) has the most progressive and antidiscriminatory language of all policies reviewed.

Recommendation: The language of the National Standards for Treatment and Rehabilitation of Person with Substance Use Disorders on treatment and nondiscrimination should become standard for other policy documents in Kenya.

Sexual and reproductive health and rights

Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safer sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (World Health Organization, 2011, p. 20)

Several documents provide guidance in Kenya on sexual and reproductive health and rights. However, the National Reproductive Health Policy states that enjoyment of these rights must be within the sphere of Kenyan law. This is disadvantageous to key populations, whose behaviors that put them at risk of HIV are proscribed by the law. Other policy documents also largely ignore the sexual and reproductive health and rights of key populations. Consequently, sex workers, transgender people, and men who have sex with men have limited access to sexual and reproductive health services.

Recommendation: Policy should ensure that the sexual and reproductive health and rights of key populations are protected. Policy should also enforce nondiscrimination standards to ensure that all groups can access health services regardless of their health status, source of income, sexual orientation, or gender identity.

ABBREVIATIONS

ART	antiretroviral therapy
CCM	country coordinating mechanism
CSO	civil society organization
EMR	electronic medical records
FSW	female sex worker
GBV	gender-based violence
GOK	Government of Kenya
HCT	HIV counseling and testing
IEC	information, education, and communication
KHRC	Kenya Human Rights Commission
KNASP	Kenya National AIDS Strategic Plan
KNCHR	Kenya National Commission on Human Rights
MAT	medication-assisted therapy
MMS	Ministry of Medical Services
MOH	Ministry of Health
MOPHS	Ministry of Public Health and Sanitation
MSM	men who have sex with men
NACADA	National Campaign against Drug Abuse Authority
NACC	National AIDS Control Council
NASCOP	National AIDS and STI Control Programme
NGHRC	National Gay and Lesbian Human Rights Commission
NGO	nongovernmental organization
NSP	needle and syringe program
OST	opiates substitution therapy
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PWID	people who inject drugs
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infection
SW	sex worker
TB	tuberculosis
TG	transgender people
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

ASSESSMENT FINDINGS: FRAMEWORK

1. Coordination and Integration

The right to health, like all human rights, imposes three types or levels of obligations on state parties: the obligations to respect, protect, and fulfill. The obligation to respect requires states to refrain from interfering directly or indirectly with enjoyment of the right to health. The obligation to protect requires states to take measures that prevent third parties from interfering with Article 12 of the Universal Declaration of Human Rights:

No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks. (United Nations, or UN, 1948)

Finally, the obligation to fulfill entails the additional obligations: to facilitate, provide, and promote. It requires states to adopt appropriate legislative, administrative, budgetary, judicial, promotional, and other measures supporting the full realization of the right to health (Office of the United Nations High Commissioner for Human Rights and Joint United Nations Programme on HIV/AIDS, or UNAIDS, 2006, p. 11).

International guidelines highlight the importance of a coordinated, participatory, transparent, and accountable approach to the realization of the right to health—an approach that integrates program responsibilities across all branches of government, aligns with international standards, supports international initiatives, and facilitates sharing of knowledge and information (Office of the United Nations High Commissioner for Human Rights and UNAIDS, 2006, p. 63). An effective coordination framework on behalf of key populations at higher risk for HIV exposure—men who have sex with men (MSM), transgender people (TG), sex workers (SWs), and people who inject drugs (PWID)—has the following characteristics:

- Multisectoral coordination of roles and responsibilities
- Coordination among related health programs
- Services within the prison system targeting national health goals
- Evidence-based decision making in setting program priorities, budgets, and approaches for services

Opportunities for coordinating services for key populations become clear when policymakers understand how gender, race, citizenship, religion, and socioeconomic status are connected to sexual risk and resilience and acknowledge the role that violence plays in initiation into sex work, with its higher attendant risk of acquiring HIV (International Center for Research on Women, United Nations Development Program, and Global Coalition on Women and AIDS, 2009; World Health Organization, or WHO, 2000). The vast majority of the policy documents reviewed call for coordination among government ministries. Because key populations interact with different governmental sectors, this coordination is particularly important. For example, Kenya's Ministry of Health (MOH) would lead the national HIV response and involve other sectors of the government (Ministry of Medical Services (MMS) and Ministry of Public Health and Sanitation (MOPHS), 2013; Government of Kenya, or GOK, 2012 [1986]; National AIDS Control Council, or NACC, 2009), while law enforcement would be under the police department (GOK, 2006a). However, it is not clear how integration between and/or across the different sectors for people with criminalized behaviors and identities who need HIV-related services would be realized.

Indeed, even within government programs on such topics as sexual and reproductive health and rights (SRHR), sexually transmitted infection (STI), HIV, tuberculosis (TB), dependence treatment, and

harm reduction, no system exists to identify, integrate, and coordinate issues pertaining to key and vulnerable populations, leading to missed opportunities to expand points of entry into care and to improve treatment adherence and health outcomes. Similarly, the Workplace Policy on HIV/AIDS (Ministry of Labour, 2007) does not mention SWs, PWID, TG, or MSM. Indeed, the only mention of nondiscrimination in the policy is in the context of real or perceived HIV status (p. 2).

Development policies do identify HIV as a major health challenge in Kenya. The Second Medium Term Plan (2013 – 2017) notes that the main causes of death in Kenya are:

...HIV/AIDS (29.3%), perinatal conditions (9.0%), lower respiratory infections (8.1%), Tuberculosis (TB) (6.3%), diarrhoea (6.0%) and malaria at (5.8%) among others. (GOK, 2013, p. 77)

This plan, which operationalizes the longer-term Vision 2030, notes the need to expand HIV services to reduce prevalence from the current rate of 5.7 percent to 4 percent by 2017 but fails to mention any of the key populations. Other development policies, including the ruling party's manifesto (Harmonised Jubilee Coalition Manifesto, 2013), only recognize HIV as a growing health challenge but fail to provide any detailed strategies on how to deal with it, especially on a population basis. Consequently, there is no mention of PWID, TG, MSM, or SWs in the documents.

The Kenya National Social Protection Policy notes that Kenya has a number of vulnerability-based laws to protect the rights of the disadvantaged. These include the National Children's Policy (2010) and the Children's Act (2001); the National Policy on Older Persons and Aging (2009); the National Policy on Youth (2006); the National Gender and Development Policy (2000); and the Persons with Disabilities Act (GOK, 2012 [2003]). However, these laws and policies are largely not in tune with the Constitution and its rights-based framework (Ministry of Gender, Children, and Social Development, 2011, p. 11).

The National Social Protection Policy attempts to address this gap by basing social protection on the Constitution, Articles 20 and 43.

Article 20 (5) of the Constitution declares that it is the duty of the State to allocate sufficient resources to ensure the achievement of constitutional rights. In the case of any right listed under Article 43 (ESC Rights) and in allocating resources, the State must give priority to ensuring the widest possible enjoyment of the right given the prevailing circumstances, including the vulnerability of particular groups or individuals. (Ministry of Gender, Children, and Social Development, 2011, p. 29)

The policy urges coordination and integration to avoid "duplication and inconsistencies in the operation and implementation of interventions throughout the country" (Ministry of Gender, Children, and Social Development, 2011, p. 22). Unfortunately, it does not recognize key populations among vulnerable groups even in specific references to HIV.

The Ministry of Education's strategic plan for 2008–2012 does mention the need for coordination with the MOH, through mechanisms such as the inter-agency coordination committee. The plan also notes the need for internal and external mainstreaming of HIV issues (Ministry of Education, 2008, pp. 17, 54).

2. Data-informed Planning and Budgeting

Understanding the size of the target population provides a basis to identify the burden of disease and service capacity needs. It also provides a critical foundation for advocacy, resource and program planning, measurement of coverage, and monitoring and evaluation of programs. Although many countries may have national population prevalence estimates, advocacy and programming for MSM, TG, and SWs require data specific to these populations. In addition, because these groups may not be

distributed uniformly across a country, local or regional data are important for program planning and resource allocation (UNAIDS/WHO, 2003).

Kenya does not have guidelines on population size estimation and the first surveillance report was published only in 2012. The report notes that the need for effective interventions among key populations is increasingly recognized in Kenya's national HIV response, but says there is a paucity of data on the characteristics, sexual behavior, and other risk factors of these populations and few estimates of population sizes to guide effective interventions at all levels (MOH and National AIDS and STI Control Programme, or NASCOP, 2012, p. i). The Kenya National AIDS Strategic Plan (KNASP) 2009/10–2012/13 recognizes the challenge in getting the actual numbers of key populations:

KNASP III uses the latest model default estimates to arrive at 80,000 sex workers for planning purposes. MSM are a significant population but their size is difficult to estimate. IDU [injecting drug users] is increasing in Kenya, but again real numbers and their distribution remain unknown. (NACC, 2009, p. 6)

There are many reasons why key populations may not take up treatment for STIs: among them, stigma and discrimination, real or imagined potential for violence, and fear of arrest and prosecution. The National Reproductive Health Policy erects an additional barrier, because it confines the enjoyment of sexual and reproductive rights to the context of law (MOH, 2007). However, the same policy provides that

...all people have the right to decide freely and responsibly on all aspects of their sexuality, and have the right to be free from conditions that interfere with sexual health such as harmful practices; sexually acquired conditions including sexually transmitted infections (STIs) and HIV/AIDS. (MOH, 2007, p. 3)

Other policy documents identify service packages for SWs (NASCOP and MOPHS, 2010) and for PWID (MOH, 2013b) but not for MSM and TG.

Kenya's policy documents, such as the National RH Policy, National RH and HIV/AIDS Integration Strategy, Kenya National AIDS Strategic Plans II and III, recognize the burden imposed by STIs/RTIs [reproductive tract infections] and the need to integrate RH-HIV services. (MOPHS and MMS, 2010, p. 11)

Thus, even though there is clear recognition of the need to integrate STI, HIV, and reproductive health services, there is no acknowledgment of service needs specific to TG and MSM and no clear policy guidelines exist.

ASSESSMENT FINDINGS: COMMUNITY PARTNERSHIP

3. Community Engagement and Participation

... persuasive evidence from 40 years of development projects [shows] that projects with substantial community engagement are more likely to succeed. (Joint United Nations Programme on HIV/AIDS, 2012, p. 15)

Despite recommendations by leading international technical agencies on meaningful involvement of key populations in HIV policymaking processes, these populations are often either excluded or denied sufficient influence. Strong partnerships between the government and the community at different levels help to identify the barriers that key populations face in accessing services and help reinforce implementation of appropriate policies and programs.

In many countries, although there may not be a policy preventing nongovernmental organizations (NGOs) or civil society organizations (CSOs) from serving key populations, formal registration process can be delayed indefinitely, effectively blocking the establishment and funding of these organizations (Duvall, Beardsley, Campaoré, Sanon, and Bassonon, 2012). There may also be policies that deny or withdraw registration of CSOs providing services to MSM, TG, or SWs. Sodomy laws and pervasive social intolerance force those who work on these issues to do so as secretly and anonymously as possible (Kisia and Wahu, 2010).

In Kenya, organizations representing key populations have been denied registration on the grounds of contravening “public order” or “public morals.” In 2012, the National Gay and Lesbian Human Rights Commission (NGHRC) filed a case in court after it was denied registration by the NGO Council of Kenya. The council said that the terms “gay” and “lesbian” were unacceptable in the organization’s name and should be reviewed together with the stated objectives of advocacy for human rights by NGHRC, because such advocacy would contravene the law. In a replying affidavit, the Attorney General said that gays and lesbians are entitled to their inherent dignity as human beings. However, he said,

... owing to the constitutional, legal, social and religious settings that overwhelmingly negate the promotion of gay and lesbian practices, the granting of orders sought [registration] could be, at the risk of offending legal, religious and social tenets of Kenyan society, be construed to mean that gays and lesbians have a right to promote their lifestyle and to convert others into gay and lesbian lifestyle. (Republic of Kenya, 2013)

The Constitution requires public participation as one of the national values and principles of governance, which are:

[p]atriotism, national unity, sharing and devolution of power, the rule of law, democracy and participation of the people (GOK, 2010, p. section 10 [2] a)

Therefore, all decision-making processes in the country and any policies made after the passing of the Constitution in 2010 should provide for public participation. Unfortunately, this is yet to be fully realized, particularly by key populations.

The lack of involvement in decision making prevents key populations from voicing their concerns and needs to government officials and from advocating the availability, increased coverage, and better quality of services responding to their needs. In so doing it undermines efforts to remove criminalizing and stigmatizing approaches from national policies.

A noteworthy exception is Kenya’s policy on medically assisted therapy for PWID, which says that HIV programs should hire TG staff to work with TG clients (MOH, 2013).

ASSESSMENT FINDINGS: LEGAL ENVIRONMENT

4. Authorization

The way the policy and regulatory environments describe authorization is important, because authorization gives permission to provide services and can formalize funding of these services. Further, it identifies the oversight mechanisms that may drive the philosophy of service provision.

Legal silence on evidence-based services is probably one of the major reasons why HIV strategies and programs are not specific or binding. Because the law does not require access to specific services, policymakers are reluctant to mandate specific actions and indicators in lower-level policies and resort to broad or unclear statements. As a result, executive bodies are not held accountable for ensuring the availability and quality of services, and advocates cannot refer to national strategies and programs to support their demands for access to core interventions.

Policies are often declarative in nature, amounting simply to statements of the government's intentions or desired outcomes without identifying specific implementation mechanisms (Duvall, Beardsley, Campaoré, Sanon, and Bassonon, 2012). For example, a program may recognize MSM, TG, SWs, PWID, and inmates as priority groups without explicitly guaranteeing access to evidence-based interventions, such as condoms, HIV counseling and testing (HCT), and STI services, or set service coverage targets specific to these populations.

KNASP III (NACC, 2009, p. 6) provides HIV prevention for key populations in detention settings and in the community. The National Reproductive Health Policy (MOH, 2007) also asserts sexual reproductive health and rights services for everyone:

...all people have the right to decide freely and responsibly on all aspects of their sexuality, and have the right to be free from conditions that interfere with sexual health such as harmful practices; sexually acquired conditions including sexually transmitted infections (STIs) and HIV/AIDS. (National Reproductive Health Policy, MOH, 2007 p.3)

However, the same policy restricts enjoyment of these rights to the confines of the law. For criminalized groups then, enjoyment of these human rights and freedoms cannot be guaranteed.

Human rights and freedoms must be respected by all, regardless of religion, culture and socio-economic status. Reproductive and sexual health rights, within the context of the law, are components of human rights. (MOH, 2007, p.3)

Kenya's Health Sector Strategic Plan also recognizes the need to contain conditions causing major disease burden, with efforts focusing on the top ten causes of morbidity and mortality. HIV is the leading cause of death in Kenya, accounting for about 30 percent of all deaths (MMS and MOPHS, 2013, p. 6). However, the plan focuses only on unsafe sex (MMS and MOPHS, 2013, p. 15) and does not address issues related to the risks faced by key populations.

The guidelines on the management of sexually transmitted and reproductive tract infections do not speak of services for inmates, presumably because they do not acknowledge that sexual activity occurs in detention settings. Their definition of sex precludes same-sex sexual activity:

The reproductive organs function to propagate the human species, a function that requires sexual union of the male and female organs. (MMS and MOPHS, 2009, p. 14)

In detention settings, medical officers make health decisions for inmates. The Kenya Prisons Act states:

A medical officer may, whether or not a prisoner consents thereto, take or cause or direct to be taken such action (including the forcible feeding, inoculation, vaccination and any other treatment of the prisoner, whether of the like nature or otherwise) as he may consider necessary to safeguard or restore the health of the prisoner or to prevent the spread of disease. (GOK, 2012 [1977]), p. 15)

The lack of a published policy for prisoners on HIV also creates a policy silence on appropriate authorization for programs serving inmates. Thus, even though KNASP III categorizes prisoners as a population at risk and notes that HIV services can be highly cost-effective, existing services are not authorized by policy.

The other highly cost-effective interventions are in high-risk groups defined by specific behaviour or situations, such as prisoners, MSM, injecting drug users, sex workers, and fishing communities. (NACC, 2009, p. 4)

The effects of this policy silence were underscored in Parliament during a debate on anti-gay laws, illustrating that the government is aware of the HIV challenge among key populations:

From all the data by the National AIDS Control Council (NACC) and the National AIDS and STI Control Programme (NAS COP), the highest prevalence rate is among this section of our society. I think it is for the leadership to engage. It is for us to have dialogue. (Hon. Aden Duale, National Assembly, March 26, 2014)

Consent for testing and treatment

While there is no argument that HIV and STI testing and treatment must be available to SWs, PWID, MSM, and TG, these services need to follow the basic tenets of self-determination, privacy, informed consent, and protection. Mandatory or coercive testing is never appropriate and opens individuals to police abuse, extortion, and invasion of privacy (WHO, United Nations Population Fund, Joint United Nations Programme on HIV/AIDS, Global Network of Sex Work Projects, 2012).

The declaration on the promotion of patients' rights in Europe, adopted by the European Consultation on the Rights of Patients (WHO, 1994, p. 11), states that the informed consent of patients is a prerequisite of any medical intervention. The right to informed consent may be abused if policies do not set requirements or specify components and procedures for informed consent (e.g., the nature of testing or treatment, risks and benefits, and the right to refuse intervention at any stage without punishment). For instance, laws may state that citizens and their legal representatives have the right to refuse testing and treatment at any stage, and refusal should be provided in written form.

However, if the law lacks provisions requiring healthcare providers to obtain informed consent from patients, it may be interpreted to mean that the absence of written refusal from a patient counts as informed consent. Similarly, HIV legislation and policies stating the voluntary nature of testing for HIV often fail to specify the procedures for informed consent. Legal silence on the right to informed consent and related procedures may lead to vague policies that lack details on service providers' responsibilities.

For example, policies may say that voluntary testing for HIV is done with a person's informed consent, but fail to provide details on how this consent should be obtained (oral or written), or what kind of information should be provided to the client. In this case, if the patient does not make any objections, service providers may assume that consent has been obtained, effectively violating the requirement for informed consent (United Nations Office on Drugs and Crime, or UNODC, and Canadian HIV/AIDS Legal Network, 2010).

In Kenya, policy documents range from those that require explicit written consent (NAS COP and MOPHS, 2013b, p. 18) to those that say that verbal consent is adequate (NAS COP and MMS, 2011, p. 162), to others that fail to describe in detail how this consent is to be obtained (MOH, 2006a, p. 15).

The HIV and AIDS Prevention Act (GOK, 2006a) provides that no person shall undertake an HIV test in respect of another person except

(a) with the informed consent of that other person;

(b) if that person is a child, with the written consent of a parent or legal guardian of the child: Provided that any child who is pregnant, married, a parent or is engaged in behaviour which puts him or her at risk of contracting HIV may, in writing, directly consent to an HIV test (GOK, 2006a, p. 12)

The act also states that a medical practitioner can undertake HIV tests without consent if:

(i) the person is unconscious and unable to give consent; and

(ii) the medical practitioner reasonably believes that such a test is clinically necessary or desirable in the interest of that person (GOK, 2006a, p. 12)

Similarly, no person can undertake human biomedical research without the written consent of the person from whom blood or body tissue will be removed. If the person lacks capacity to give such consent, then it must be obtained from a parent or legal guardian (GOK, 2006a, p. 21).

The act does not give guidance on whether consent for research has to be given in private, or indicate conditions for withdrawal from research. It does, however, indicate that one should be made aware of the “aims, methods, anticipated benefits and the potential hazards and discomforts of the research (GOK, 2006a, p. 21).”

“Guidelines for Implementing TB-HIV Collaborative Activities in Kenya” (MOH, 2006a) notes that a TB patient should be tested for HIV, but does not make this mandatory.

DTC [diagnostic testing and counseling] is offered in the context of consent, counselling and confidentiality (3C's). Considering that TB patients are within the health system throughout their medication period (8 months), those who decline initially should also be reminded in subsequent visits of missed opportunities. (MOH, 2006a, p. 15)

Additionally, these guidelines say that all HIV-positive patients should be offered TB screening; the policy is silent on whether symptomatic individuals can decline (MOH, 2006a, p. 15). The policy for prison settings, however, appears to suggest that TB screening is mandatory:

All inmates on admission should be screened for TB. The prison and remand cell should follow and implement TB infection control guidelines. There is need for active advocacy and sensitization of the relevant ministry and departments for the implementation of TB infection control guidelines in the prisons. (MOPHS, 2010, p. 23)

The guidelines for medically assisted therapy for PWID require people to give consent before enrolling in programs (NASCOP and MOPHS, 2013b, p. 18), and say this should be given in writing. These guidelines also allow people to stop treatment if they wish:

...before enrolment for opioid agonist maintenance treatment (OAMT), every client needs to sign a patient treatment contract for OAMT. It is important to inform them about the dosing schedules and procedures, rules and regulations to enable clients to give informed consent in writing. The information needs to be in a language and form that clients can understand. The patient has a right to refuse or stop treatment. (NASCOP and MOPHS, 2013b, p. 18)

Unfortunately, the ability of prisoners to consent to TB and HIV testing and treatment seems to be severely constrained by the Kenya Prisons Act:

A medical officer may, whether or not a prisoner consents thereto, take or cause or direct to be taken such action (including the forcible feeding, inoculation, vaccination and any other treatment of the prisoner, whether of the like nature or otherwise) as he may consider necessary to safeguard or restore the health of the prisoner or to prevent the spread of disease. (GOK, 2012 [1977]), p. 15)

Although the harm reduction and drug dependence treatment guidelines describe in detail how consent is to be obtained, they do not mention the needs of SWs, MSM, and TG or the risks they run if their criminalized status is revealed.

5. Privacy and Confidentiality

To safeguard patients' rights to privacy and confidentiality, international clinical practice guidelines require the protection and confidentiality of medical records. Policy and practice regarding confidentiality may have an impact on the willingness of key populations to access services and to provide information necessary for quality care.

Public health surveillance is the ongoing systematic collection, analysis, and interpretation of health data. It includes the timely dissemination of the resulting information to those who need it for action. Surveillance is essential for planning, implementation, and evaluation of public health practice. (Ministry of Health, 2012, p. 3)

Disclosure by health service providers of information regarding HIV status and MSM, TG, or SW identity to law enforcement agencies has been reported in numerous countries around the world, even in settings where healthcare legislation requires the confidentiality of patients' information. In most cases, laws protecting confidentiality are contradicted by other provisions in health- or law enforcement-related policies that grant access to health records by prosecutors, police, and other agencies without court authorization. Laws may allow disclosure of personal health information without the consent of a patient or his/her legal representative or without court authorization to initiate criminal investigation or prosecution.

The Kenya National Patients' Rights Charter (MOH, 2013d), the HIV and AIDS Prevention and Control Act (GOK, 2006a), and the Standards and Guidelines for Electronic Medical Record Systems in Kenya (MMS and MOPHS, 2010) are the principle policy documents that guide how patient information is stored, tracked, and shared. The HIV and AIDS Prevention and Control Act states that no one shall record, collect, transmit, or store records, information, or forms regarding HIV tests or related medical assessments of a person other than in accordance with the privacy guidelines. The Act further states that no one shall disclose any information concerning the result of an HIV test or any related assessments to anyone other than the person tested without that person's written consent (GOK, 2006a, pp. 14–15).

According to the electronic medical records (EMR) policy (MMS and MOPHS, 2010), the EMR systems must address basic demographic and clinical health information, clinical decision support, order entry and prescribing, health information and reporting, security and confidentiality, and exchange of electronic information. Most population-specific policies would provide for privacy and confidentiality of medical health records.

In addition, standard operating procedures on medically assisted therapy provide that

[a]ll persons receiving treatment for substance use disorders have a right to privacy and confidentiality of their health records. (NAS COP and MOPHS, 2013b, p. 11)

Although these policies provide for confidentiality, other policies, particularly those relating to criminal and justice systems, appear to contradict the privacy and confidentiality of key populations. An example is the Evidence Act (GOK, 2009 [2008]), which provides conditions for admissible evidence but says nothing about the discovery and admissibility of medical, mental health, and drug dependence treatment records. It is also silent on drug dependence treatment.

Although the Evidence Act requires that samples taken for legal proceedings be stored at an appropriate place until the trial ends, it offers no clear provisions for guarding the privacy and confidentiality of an accused person's medical status. A draft policy on HIV and STI programming for key populations does note the importance of keeping medical records of criminalized groups confidential.

Client data, especially that which identifies individuals and locations should be treated with care so that it does not fall into the wrong hands, for example, the police, who have a mandate to curtail illegal activities. Community sensitive data should be stored under lock and key. Overall estimates should not be given to the media, as the publication of figures may result in unintended political or law enforcement action. This will push high-risk groups underground, further increasing their vulnerability to HIV. (MOH, 2014a, p. 31)

None of the policy documents explains how the apparent contradiction between the Sexual Offences Act (GOK, 2006b) and the MOH's draft policy for HIV and STI can be resolved. Even though the Kenya National Patients' Rights Charter (MOH, 2013d) affirms the right to confidentiality, it states that the right shall be upheld except where consent has been expressly given or disclosure is allowed by law or in the public interest. The Code of Conduct and Ethics for nurses in Kenya (National Nurses Association of Kenya, 2009) states that information on patients should be handled within the law, but also forbids public gossip about patients:

Disclosure of information shall be strictly done within rules and guidelines as provided for by various institutions and relevant laws and consent of the patient where applicable shall be obtained. Public gossip about a patient shall not be tolerated. Confidentiality must be maintained at all times. (National Nurses Association of Kenya, 2009, p. 5)

6. Registries

Policy and practice regulating data collection and management have implications for protection of privacy and confidentiality, and consequently for access to services. When data collection and management systems are known or suspected to insufficiently protect records, or are responsible for discriminatory actions, those with criminalized identities or behaviors, such as PWID, MSM, TG, or SWs have an incentive to avoid the health services collecting these data (Beardsley, 2013).

Several databases in Kenya collect and store essential public health data, including data related to key populations. Public health surveillance data in Kenya includes information on STIs, HIV, and TB (MOH, 2012, p. 17). The National Drug Control Authority, an autonomous body reporting to the National Assembly, is authorized to collect, analyze, and disseminate data on drug use (GOK, 2011, p. Pt 5[s]). Hepatitis is not included in these surveillance systems.

Guidelines for implementing the Sexual Offences Act identify data registration requirements for laboratory results and post-rape care. They offer minimal guidance on keeping these registries secure, and none on handling data that may indicate illegal behavior, such as same-sex exposure or sex work (MMS and MOPHS, 2009).

Law enforcement registries include a register for convicted sexual offenders, which is open to examination by "any person who has a reasonable cause to so examine it" (GOK, 2006b, p. Pt 39 [13]). Registration of drug users is not identified in the primary drug control legislation or information on drug possession penalties (GOK, 2012 [1994]), (Kenya Police). The National Infection Prevention and Control Guidelines for Health Care Services in Kenya discusses surveillance of healthcare-associated infections, but does not categorize these in terms of key populations (MOPHS and MMS, 2010b, p. 15).

The Standards and Guidelines for Electronic Medical Record Systems in Kenya (MMS and MOPHS, 2010) and the Kenya National Patients' Rights Charter (MOH, 2013d) provide for the protection of a patient's confidentiality, but do not explicitly extend this protection to specific medical conditions or

to key populations, even though suspicion of criminalized behavior could lead someone to release records in service of the law or their own moral convictions.

Law enforcement maintains a register of sexual offenders, which is open to examination by “any person who has a reasonable cause to so examine it” (Government of Kenya, 2006, p. Pt 39[13]). Although MSM and SWs are not categorized as dangerous sexual offenders, profiling by police officers of individuals based on known or suspected sexual practices is possible. A report by the Kenya National Commission on Human Rights (KNCHR) observes:

They [MSM & SWs] are profiled as drug users, past prison convicts or individuals with track records of crimes. They often face arbitrary arrest, are often detained at the police stations, subjected to torture and unnecessary harassment by the police who extort money from them and are only released after bribing their way out. (KNCHR, 2012, p. 94)

7. Stigma and Discrimination

Policies that address stigma and discrimination are particularly important in a country such as Kenya where religious beliefs and customs, including gender norms for men and women, and laws that criminalize same-sex sexual relations, drug use, and sex work create a highly stigmatizing environment for key populations.

The Constitution prohibits discrimination and gives all people equal protection and benefits of the law. It identifies a long list of grounds on which discrimination is prohibited, including health status, disability, and dress (GOK, 2010, p. Art 27). Discrimination in employment on grounds of disability, mental status, or HIV status is also prohibited by the Employment Act of 2012 (Employment Act, Chapter 226, 2012, p. Sect 5[3], GOK, 2012 [2007]). The act also outlaws discrimination against migrant workers and seeks to ensure that employment policy and practices are nondiscriminatory. The law also outlaws forced labor (GOK, 2007, pp. 367–369). Furthermore, Kenya’s housing policy maintains that it is the government’s responsibility to “endeavour to protect the interests and rights of the poor and marginalized groups against unjustified evictions and exorbitant rents” (National Housing Policy for Kenya, Sessional Paper No. 3 of 2004).

The Penal Code outlaws incitement of “death or physical injury to any person or to any class, community or body of persons” (Penal Code, Chapter 63, 2012 [2010], p. Sect 96). There is also fairly consistent policy language that identifies the supremacy of the constitutional laws of Kenya over customary, cultural, and religious practices (GOK, 2010, p. 2[4]), (Sexual Offences Act, 2006b, p. Sect 29), (Protection against Domestic Violence Bill, 2012, p. Sect 3 [1], GOK, 2012h).

Commitment to nondiscrimination is illustrated in a strategy that NASCOP is drafting for communication with key populations; its goal is “zero stigma and discrimination” (NASCOP, unpublished). The guidelines for drug-use treatment and harm reduction, TB services, and HIV and STI programming also acknowledge stigma and discrimination, the barriers they present to service access, and the need for explicit mechanisms to measure and reduce stigma and discrimination against key populations (National Guidelines for Key Population HIV/STI Programming, MOH, draft, 2014), (Guidelines on Management of Leprosy and Tuberculosis, Ministry of Public Health & Sanitation, or MOPHS, 2009), (Kenya National Guidelines for the Comprehensive Management of the Health Risks and Consequences of Drug Use, NASCOP and MOPHS, 2013a).

The National Guidelines for HIV/STI Programs for Sex Workers describe stigma and discrimination and how to address them more clearly:

SWs suffer stigma and discrimination from health care providers, society, and law enforcement agencies that lead to barriers in accessing services and increase vulnerability to HIV/STI. To reduce the stigma associated with SW, training will be provided to sensitize health workers, program staff members, law enforcement agencies, and other relevant parties on providing “sex-worker friendly” services that protect the health and human rights of SWs. BCC [behavior change

communication] *activities may also be used to educate the public to reduce stigma and discrimination towards sex workers. . . . HIV/STI/reproductive health interventions should not only be accessible but also acceptable to sex workers. Service providers must adopt a non-judgmental, non-stigmatizing attitude and be trained in dealing with the special needs of this population. Health services must be confidential and voluntary to ensure the health and human rights of each sex worker are protected. . . . Programs are encouraged to promote community mobilization initiatives as these empower SWs to advocate for local structural changes to reduce stigma and increase access to HIV/STI services.* (NASCOP and MOPHS, 2010a, pp. 30, 66)

The National Standards for Treatment and Rehabilitation with Persons with Substance Disorders (National Campaign against Drug Abuse Authority, or NACADA, 2010) has a progressive nondiscrimination policy.

Discrimination: Treatment facilities seek to ensure that no discrimination occurs on the basis of race, class, gender, ethnicity, colour, age, location, social status, language, sexual orientation, diagnosis, disability, clinical or forensic status in the quality of care and the type of service offered. (NACADA, 2010)

This policy and the Kenya Information and Communications Act (GOK, 2009 [1998]) are the only policy documents stating that sexual orientation/preference is protected from discrimination. Yet, while this language may signal a precedent for protection from discrimination for key populations, the list of protected grounds of sexual orientation, profession/source of income, and gender identity are absent.

8. Criminal and Administrative Law: Criminalization and Punishment

International guidelines on HIV and human rights recommend the review of laws that prohibit sex between consenting adults (including sodomy) in private, with the aim of repealing them.

There is growing international consensus that the decriminalization of homosexuality is an essential part of a comprehensive public health response to the elevated risk of HIV acquisition and transmission among men who have sex with men. (Global Commission on HIV and the Law, 2012, p. 48)

Criminal and penal codes establish definitions and parameters of behavior that reflect a criminal justice perspective and identify options for enforcement and remedy.

Controlled substances

Recent policy revisions in Kenya have made it possible to put in place programs that work on harm reduction and treatment for PWID. The Narcotic Drugs and Psychotropic Substance (Control) Act criminalizes anyone possessing any narcotic drug or psychotropic substance (GOK, 2012 [1994], p. 11), but the revised act now opens the door to needle and syringe programs (NSPs), by allowing exceptions to this section of the law:

Subsection (1) shall not apply to— a person authorized under the regulations to be in possession of the narcotic drug or psychotropic substance. (GOK, 2012 [1994], p. 11)

Unfortunately, the law does not specify substance amounts that would constitute criminal liability. The medication-assisted therapy (MAT) standard operating procedures, however, indicate that MAT sites are not to be used to arrest or harass people who are seeking services or engaged in treatment (NASCOP and MOPHS, 2013b, p. 11).

The same policy document refers to opioid dependence as “a complex disease” (NASCOP and MOPHS, 2013b, p. 11), but it is not clear if this reference is of any importance in the application of the law.

The Narcotic Drugs and Psychotropic Substance (Control) Act could have a punitive effect on anyone offering aid to a person who has overdosed. This is because the act says:

without lawful and reasonable excuse, is found in any house, room or place to which persons resort for the purpose of smoking, inhaling, sniffing or otherwise using any narcotic drug or psychotropic substance; or

has in his possession any pipe or other utensil for use in connection with the smoking, inhaling or sniffing or otherwise using of opium, cannabis, heroin or cocaine or any utensil used in connection with the preparation of opium or any other narcotic drug or psychotropic substance for smoking

shall be guilty of an offence and liable to a fine of two hundred and fifty thousand shillings or to imprisonment for a term not exceeding ten years or to both such fine and imprisonment. (GOK, 1994, p. 12)

The MAT policy appears to contradict the narcotics law to the extent that it describes opioid dependence as “a complex disease” (NASCOP and MOPHS, 2013b, p. 11), thus implying that MOH recognizes the risks of overdose. In any case, the MAT policy fails to protect the people most likely to be able to seek aid for an overdose victim: other drug users in the same “house, room or place” with the victim.

Criminalization of sexual orientation and behavior

Homosexuality is criminalized in more than 80 UN member states, with punishments ranging from jail time to the death penalty. Criminalization of same-sex behavior has profound implications across the spectrum of policies, issues, and programs relating to MSM (Beyrer and Baral, 2011). Repressive legal codes and pervasive social stigma can limit these men’s access to appropriate STI and HIV services, including prevention and treatment, and can even be life-threatening (Beyrer, Wirtz, et al., 2011, p. 314). For example, in Ethiopia, MSM are punished with “simple imprisonment.” In Guyana, the prison sentence for same-sex sexual practices ranges from two years to life. In Nigeria, homosexual practices are illegal under federal law; in those parts of the country under sharia law, sentences include death by stoning (Foundation for AIDS Research and John Hopkins Bloomberg School of Public Health, 2012, p. 13).

Legal sanctions have a profound effect on MSM, who may go underground and hence become less accessible to prevention, treatment, and care interventions in their area. A study of MSM health-seeking behavior in Senegal by the Center for Public Health and Human Rights at Johns Hopkins University found that use of services declined dramatically after a police crackdown (Beyrer, Wirtz, et al., 2011, p. 314). Results of another study suggest that HIV prevalence among MSM is higher in settings where same-sex relationships are criminalized than in those where it is legal (WHO, 2011).

In Kenya, homosexuality is criminalized, with prison sentences ranging from seven to 21 years (GOK, 2009 [2008], p. 67). This worsens the already deeply entrenched stigma against MSM, and the effect is often much more devastating at a social level, because both state and nonstate actors use criminalization as justifiable grounds to impose violence on MSM, including unlawful arrests. Recently, a group of Members of Parliament vowed to “...rally [...] the public to arrest gay people where police fail to act” (*Daily Nation*, February 18, 2014).

Criminalization’s impact has been to keep MSM and other key populations from HIV services, as noted by Kenya’s Cabinet Secretary for Health:

Following the on-going debate, most of HIV care centres serving key populations have been closed. In addition, there is increased fear, stigma, discrimination and potential acts of violence against the key populations, further limiting access to health services while continuing with risky behaviours. (Daily Nation, February 28, 2014)

Criminalization of sex work

Laws that aim to prevent or regulate sex work can deeply undermine the human rights of SWs. A myriad of regulations, civil and administrative laws, and criminal laws are aimed at stopping public disorder, prostitution, human trafficking, and immorality. These shape where and how SWs live and work. Laws against sodomy, cross-dressing, and public order offenses (for example) may affect male and transgender SWs differently (Global Network of Sex Work Projects, 2011, p. 76).

Criminalization of voluntary sex work, including laws prohibiting commercial sex work, soliciting, pimping, brothel keeping, and human trafficking can also adversely affect access by SWs to HIV prevention, treatment, and care. In Kenya, the Penal Code does not directly criminalize sex work, but it criminalizes living on earnings from prostitution or aiding prostitution (GOK, 2012 [2010], p. 59).

City and town councils in Kenya have bylaws that prohibit the following:

molest, solicit or importune any person for the purposes of prostitution or loiter on any street or public place for such purpose; or

loiter on any traffic island constructed in any street or thoroughfare, or in any way interfere with or obstruct pedestrian traffic. (Local Government Act, 2008, p. 4)

Because these laws are general, they are subject to diverse interpretation by local government judicial officers, in ways often prejudicial to sex workers. According to KNCHR:

Testimonies received from sex workers indicated that they suffer a lot of difficulties and violations in the course of their work. These include the following:

- *Violence from their clients who demand for sex and sometimes decline to pay;*
- *Rape and harassment by law enforcement agents;*
- *Arrests by police officers who extort money from them;*
- *Stigma and discrimination of both the sex workers and their children by the society;*
- *Exposure to HIV transmission when their clients refuse to use condoms or engage in rough sex that tears the condom during the intercourse;*
- *Exploitation by male clients who pay very little for the services;*
- *Stigma and discrimination as they are labelled as “sinners” or evil people who should not access spiritual services in places of worship.”* (KNCHR, 2012, p. 97)

Sex workers who participated in this decision model project’s community engagement reported that these subsidiary laws put them at increased risk of harassment. They said when they are arrested, having condoms is used as evidence against them. Criminalization and police harassment can also place SWs in unsafe and exploitive working conditions that make condom negotiation more difficult. Moreover, criminalization legitimizes social stigma and discrimination against SWs.

Referral to services rather than prosecution

Prosecution of MSM, PWID, TG, and SWs can be a major barrier to prevention efforts, adoption of safer sex behaviors, and access to support and care services. These populations may avoid HIV testing and services for fear of prosecution and are often forced to hide, making it harder for them to access services and for outreach efforts to find them. It is therefore important for the country to adopt a

policy of referral to services rather than prosecution. Even in situations where the law criminalizes behaviors of key populations, upon conviction, noncustodial sanctions should be considered rather than detention, which increases the risk of exposure to HIV and limits access to prevention and treatment resources.

9. Gender-based Violence

Gender-based violence (GBV) targets individuals or groups because of their gender or adherence to gender norms. Not all survivors of GBV are female. Indeed, a population-based survey on violence against children in Kenya found that:

32% of females and 18% of males experience sexual violence; 66% of females and 73% of males experienced physical violence; 26% of females and 32% of males experience any violence as a child; and 13% of females and 9% of males experienced all three types of violence during childhood. (United Nations Children's Fund, United States Centers for Disease Control, and Kenya National Bureau of Statistics, 2012)

MSM and TG may also be harassed, beaten, or killed, because they do not conform to society's dominant views of masculinity (Beardsley, 2013).

The Sexual Offences Act of Kenya contains broad gender-neutral definitions of penetration, which are inclusive of genital organs, body parts, or objects, and refers to perpetrators and victims as persons rather than male or female. These definitions apply to rape, sexual assault, and defilement. The act's definition of incest is gender-specific, identifying males who commit sexual crimes against female relatives and females who commit sexual crimes against male relatives. Punishments are equal for rape, sexual assault, and incest and progressively longer (ranging from 15 years to life) for defilement, depending on the age of the victim (GOK, 2006b). Likewise, the Protection against Domestic Violence Bill defines spouse and victim as either male or female and is inclusive of domestic relationships, such as marriage, living in the same household, and close personal relationships. The bill does not appear to cover the contractual relationship between a sex worker and his/her clients as one that is eligible for protections against sexual violence (GOK, 2012h).

Both pieces of legislation identify abuse and violence resulting from cultural, customary, or religious practices as offenses (GOK, 2006b, p. Sect. 29), (GOK, 2012h, p. Sect. 3).

Domestic violence may be reported by "any person who has a reason to believe that an offense involving domestic violence is being or has been committed," and this individual is guaranteed anonymity (GOK, 2012h, p. Sect. 9). In addition, while the Sexual Offences Act specifically excludes consideration of previous sexual experience or previous conduct of an alleged perpetrator as evidence, there are no restrictions on evidence that can be brought to bear in the determination of a case of domestic violence (GOK, 2012h, p. Sect 36). Both of these clauses of the Domestic Violence Bill create risks for members of key populations, because the first removes their consent from the process of engaging with law enforcement and the second may expose them to discovery of evidence of criminalized behaviors.

The National Guidelines on Management of Sexual Violence in Kenya (MOPHS and MMS, 2009a) identify medical and psychosocial services for male and female survivors of sexual offenses, including postexposure prophylaxis for HIV and other STIs and emergency contraception. This document also contains strong guidance on consent. While there are no explicit restrictions on services for key populations, there are also no specific guidelines or referral mechanisms for the specific needs of these groups.

As a group, populations with criminalized behaviors, such as MSM, PWID, SWs, and TG, may have more experience with the harm associated with detention and prison settings. Gender nonconforming attributes can also make individuals more vulnerable to sexual abuse while detained in hyper-masculine and aggressive prison environments, where individuals perceived as MSM or SWs are

often assumed to have consented to sexual activity (National Prison Rape Elimination Commission, 2009).

Kenyan law requires separate housing for males and females in detention and prison settings (GOK, 2012 [1977], p. Sect 36). The law also requires zero tolerance for sexual harassment, abuse, and exploitation in prison, with related surveillance, sanctions, education, and reporting mechanisms (Ministry of Home Affairs, 2006, pp. 12, 17). Unfortunately, there is no guideline on the handling of transgender inmates.

10. Torture and Cruel, Inhuman, or Degrading Treatment or Punishment

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation. (Article 7, International Covenant on Civil and Political Rights)

MSM, TG, and SWs are disproportionately subjected to violence of a sexual nature or corporal punishment that can amount to cruel, inhuman, or degrading punishment or even torture—reprisals directly targeting their transgression of gender roles. Prohibitions in international human rights law forbidding torture and other cruel, inhuman, or degrading treatment or punishment apply to conditions of confinement, not only in detention settings but also in medical and other institutions.

Article 28-29 of the Constitution (GOK, 2010, pp. Section 28–29) provides that every person has inherent dignity and the right to have that dignity respected and protected. It adds that every person has the right to freedom and security, which includes the right not to be deprived of freedom arbitrarily or without just cause; the right not to be detained without trial, except during a state of emergency; the right not to be subjected to any form of violence from either public or private sources; the right not to be subjected to torture in any manner, whether physical or psychological; the right not to be subjected to corporal punishment; and the right not to be treated or punished in a cruel, inhuman, or degrading manner.

Gays flee Mombasa over public attacks – BY MARTIN MWITA

HUNDREDS of men who have sex with men at the Coast have moved away from major towns for fear of their lives.

According to statistics by the Mtwapa Initiative for Positive Empowerment (MIPE), an organisation working with MSMs in Mombasa and Kilifi counties, more than 200 of the men now avoid public health facilities.

MIPE says a number of the homosexuals default from HIV treatment for fear of victimisation following the heightened debate about homosexuality in the country.

The debate, escalated by the passing of harsh antigay law by the Uganda government, is reported to have subjected MSMs at the Coast to psychological torture, public humiliation and even violent attacks by the public.

Speaking to the Star yesterday, MIPE director Evans Gichuru said they have recorded more than 20 cases where MSMs have been abused in public, forced to alight from public service vehicles and stopped from buying commodities from shops especially in Mtwapa and Mombasa.

“The cases have become more rampant following the Uganda case. We are afraid they may go even into institutions like colleges and schools, where anyone with feminine characteristics will be targeted,” Gichuru said.

A number of Kenyans have been calling for a replica of the Ugandan law signed by President Yoweri Museveni last month, outlawing homosexuality in Uganda. According to MIPE, Mombasa has more than 1,500 MSMs with about 700 practising commercial sex work in the city.

The city also has the highest number of MSMs in the country, according to a report by the National Aids Control Council. NACC also ranks Mombasa fifth among counties with the highest HIV-Aids burden in Kenya.

--The Star, March 20, 2014 (Nairobi, Kenya)

Even with constitutional provision of protection from cruel and inhumane treatment, both state and nonstate actors feel justified to inflict violence and inhuman treatment on stigmatized populations. In 2011, in Mtwapa, Mombasa County, Muslim and Christian leaders joined hands in a social cleansing operation called “operation gays out,” which affected HIV prevention and treatment research among the MSM (*Daily Nation*, February 12, 2010).

This is not to say that these constitutional provisions are in vain. In early 2014, a local court ruled that officers at the Thika Police Station violated the rights and dignity of a transgendered woman when they stripped her in public to establish her gender. The court awarded her KShs. 200,000 (USD 2,300) in damages (*Daily Nation*, February 18, 2014). Unfortunately, not every person can withstand the public nature of a legal process, because it may lead to further stigmatization and isolation.

The Evidence Act states that confessions are generally inadmissible in court when in the opinion of the court they appear to have been obtained through threats or inducement.

A confession or any admission of a fact tending to the proof of guilt made by an accused person is not admissible in a criminal proceeding if the making of the confession or admission appears to the court to have been caused by any inducement, threat or promise having reference to the charge against the accused person, proceeding from a person in authority and sufficient, in the opinion of the court, to give the accused person grounds which would appear to him reasonable for supposing that by making it he would gain any advantage or avoid any evil of a temporal nature in reference to the proceedings against him. (GOK, 2009 [2008], p. 15)

Two policy documents in Kenya speak of sexual orientation and/or transgender identity as a human condition deserving of unique (separate) mention. These are the National Standards for Treatment and Rehabilitation of Persons with Substance Use Disorders (NACADA, 2010) and the Kenya Information and Communications Act (GOK, 2009, p. 180), which refer to sexual preference or orientation and establish harm reduction policies that mention TG identity.

The Children’s Act, 2001 (section 127) (GOK, 2001), the Bail Information and Supervision Bill (2011), the Victim Protection Bill (GOK, 2013d, and the Constitution of Kenya 2010 (GOK, 2010) do not explicitly ban extrajudicial punishments and do not cite sex work, injecting drug use, or sexual orientation as protected grounds for protection from torture.

11. Monitoring and Enforcement of Legal and Human Rights

Kenya has ratified major international conventions related to human rights, which now form part of the laws of Kenya, under the provisions of the Constitution (GOK, 2010, pp. Art 2[5], 2[6]). The Constitution also contains broad statements of the rights to education, the highest attainable standard of health, health care, and reproductive health care (GOK, 2010, p. Art 43[1]), which by ratification of international conventions also includes mental health. The Constitution also provides the right to respect and protection of inherent individual dignity (GOK, 2010, p. Art 28).

Disability is defined as “a physical, sensory, mental or other impairment... which impacts adversely on social, economic or environmental participation” (GOK, 2012 [2003], Chapter 133, p. Sec 2). While rights and protections are not specific to health conditions common among key populations (e.g., hepatitis, TB, HIV, drug dependency), there are no exclusions for these conditions. Rights and social assistance are provided to people disabled by acute chronic illnesses and people with disabilities, without mention of current or past criminalized behavior as a disqualifying circumstance (GOK, 2013c, pp. Sec 17[3], 29).

The Ethics and Anti-Corruption Commission is responsible for developing, promoting, enforcing, and investigating ethics standards and practices by public officials, and raising public awareness on ethical issues and the dangers of corruption (GOK, 2012c, Chapter 65A, 2012, p. Sect 11, GOK, 2012c). Codes of conduct for public servants exist and forbid bribery, bullying, and sexual harassment (Public Officer Ethics Act, Chapter 183, 2012), (GOK, 2012a, Anti-Corruption and Economic Crimes Act,

Chapter 65), (GOK, 2006b, Sexual Offences Act, p. Sect 23[1]), (GOK, 2012e, Leadership and Integrity Act, Chapter 182).

The government is also obligated to prevent internal displacement and to raise awareness, undertake sensitization, and protect and provide assistance to people who have been internally displaced, including those who flee their homes to avoid violations of human rights (GOK, 2012g, Prevention, Protection and Assistance to Internally Displaced Persons and Affected Communities Act, No 56 of 2012, pp. Sect 5, 6). In addition, people who have a well-founded fear of being prosecuted for reasons that include “membership in a particular social group” can be granted refugee status, unless they have committed a “serious non-political crime” (GOK, 2012 [2006], Refugees Act, Chapter 173, pp. Sect 3, 4).

The Constitution also guarantees the right to representation, and states that “fees shall not impede access to justice” (GOK, 2010, pp. Sect 48, 50). A bill currently under consideration will establish a legal aid fund to provide financial assistance in civil and criminal proceedings and constitutional matters (GOK, 2013b [draft]). Additionally, the KNCRH, an autonomous institution, receives, investigates, and advises the government on redress for alleged violations of human rights.

Despite these provisions, the police in Kenya have been described as “the state’s principal organ of domination, repression, oppression, curtailing rather than enhancing the rights of citizens,” and reforms required by the 2010 constitution have been slow in coming—in part owing to desire by the leadership to maintain the status quo (D. Kivoi and C. Mbae, 2013). The proposed reforms aim to establish values guaranteeing peace, respect for universal freedoms, and the integrity and humanity of the individual without discrimination. The Constitution, with its progressive “Bill of Rights,” also seeks to make the police force more responsive to human rights.

The new Constitution seeks to make the police more effective and more accountable, promises the establishment of independent oversight institutions, and creates a strong, unified command. To bring Kenyan laws into line with the new Constitution, a raft of legislation had to be adopted. (Amnesty International, 2013, p. 9)

Moreover, the Inspector General of Police, who is the authority that issues administrative guidelines for police work, is required to ensure that any legislation is consistent with the Constitution.

5. (1) The Commissioner may issue administrative orders, to be called Force standing orders, not inconsistent with the Constitution or the provisions of this Act or of any regulations made thereunder, for the general control, direction and information of the Force. (GOK, 2010 [1988], p. 6)

Unfortunately, the Police Act does not require that these standing orders be gazetted (GOK, 2010 [1988], p. 6), and as a result, they are not in the public domain, and it is difficult to establish whether they lay any improved foundation for the protection and facilitation of service access for key populations.

Other restrictions can be found in laws related to immigration, which can hinder individuals with criminalized behavior. Immigration is prohibited for anyone convicted of a crime that carries a prison sentence of more than three years, anyone convicted of sex crimes, and anyone whose conduct offends public morality (GOK, 2012d, Kenya Citizenship and Immigration Act, Chapter 172, p. Sect 33). The law related to registration requires documenting a person’s gender, but does not specifically limit this classification to male or female or explain how to change gender on established registration papers (GOK, 2012b, Births and Deaths Registration Act, Chapter 149, p. Sect 2[a]), (GOK, 2012i, Registration of Persons Act, Chapter 107, p. Sect 5[c]).

ASSESSMENT FINDINGS: INTERVENTION DESIGN, ACCESS, AND IMPLEMENTATION

12. Procurement and Supply Management

Supply of appropriate drugs and commodities is a critical weapon against HIV. With “treatment as prevention” becoming one of the chief strategies in the fight against the epidemic, and with biomedical prevention methods such as vaginal microbicides on the horizon, the issue of proper procurement and supply chain management is gaining attention, especially for key populations.

Under the Sixth Schedule of the Constitution, certain government functions are transferred to county governments (GOK, 2010, p. Sixth Schedule). Legal Notice 137 gives this guidance on managing the procurement of medical supplies:

Provided that until alternative intergovernmental arrangement are made, all counties shall procure commodities from the Kenya Medical Supplies Authority except where a particular commodity required by a county government is not available at the Kenya Medical Supplies Authority. (Kenya Gazette, 2013, pp. 1804–1805)

Engagement of target populations in oversight of procurement and supply management

Community-led groups must participate in choosing products such as condoms and lubricants. For example, SW groups have often advocated appropriate female condoms and vaginal lubricants, and groups of people living with HIV (PLHIV) have been known to help governments with forecasts to avoid stockouts. Advocates have also drawn attention to the importance of both condoms and lubricants for anal and vaginal sex.

The Kenyan strategic plan on HIV and AIDS acknowledges this point and states:

. . . the plan will ensure that: stock-outs are minimized, and where possible eliminated; commodities are equitably and efficiently distributed; commodities are used appropriately; various procurement and supply chain management systems are harmonized; quality control and pharmaco-vigilance is ensured; appropriate staffing mix is available countrywide; parallel information systems are made more efficient and eventually integrated; and, public oversight, guidance and monitoring processes and structures (including citizen participation) are in place. (Kenya National AIDS Control Council, 2009, p. 43)

The Kenya Medical Supplies Authority (GOK, 2013a), which replaced the Kenya Medical Supplies Agency, has the primary obligation to procure, warehouse, and distribute drugs and medical supplies for prescribed public health programs, the national strategic stock reserve’s prescribed essential health packages, and national referral hospitals. It is also mandated to collect information and provide regular reports to the national and county governments on the status and cost-effectiveness of procurement, the distribution and value of prescribed essential medical supplies delivered to health facilities, stock status, and any other aspects of supply-system status and performance required by stakeholders (GOK, 2013a, p. 5).

The Pharmacy and Poisons Act (GOK, 2012 [1989]) controls the pharmacy profession and the trade in drugs and poisons in Kenya. The purpose of the Pharmacy and Poisons board is to “regulate and control the pharmaceutical services and ensure accessibility, quality, safety and efficacy of human and veterinary medicines and medical devices.” The act gives guidelines on where and how drugs and poisons may be handled in Kenya, and by whom (GOK, 2012 [1989], p. 15).

However, the board does not seem to keep records of commodities important to key populations, such as drugs required for opioid substitution and condom-compatible lubricants. Indeed, the only policies

that mention these commodities are those related to key populations: Standard Operating Procedures for Medically Assisted Therapy for People Who Use Drugs (PWUD), Standard Operating Procedures (SOP) for Needle and Syringe Exchange Programmes (NSEP) for People Who Inject Drugs (PWID), Standards for Peer-Education and Outreach Programs for Sex Workers, National Condom Policy and Strategy, National Guidelines for HIV/STI Programs for Sex Workers, and KNASP III. The MAT strategy discusses in detail the accepted opioid substitution therapy drugs, but none of the policies offers a process for their procurement, storage, and distribution. None of these policies provides for the procurement, storage, and distribution of condom-compatible lubricants.

With devolution, governance structures adopted in the 2013 Kenya Medical Supplies Authority (Amendment) Bill assign responsibility for decisions on the types of medical supplies to be procured to the Cabinet Secretary for Health:

The Cabinet Secretary shall, in consultation with the Authority and the appropriate county government organs, determine the requirement of drugs and medical supplies in public health facilities. (GOK, 2013a, p. 5)

The role of county governments in managing health services within counties is only now being understood. Unfortunately, none of the policies on health indicates the place of public participation or the role of NGOs.

13. Overarching Services Design

Policies that promote referral and the integration of HIV services with other health services increase entry points for key populations into healthcare and related services.

Obstacles to access by key populations to interventions and services can be mitigated by using best practices in intervention design and ensuring observance of human rights. Integrating STI, HIV, SRH, and other health services can improve access to essential resources, including STI and HIV screening. A lack of such service integration and referral mechanisms can lead to lost opportunities to reach key populations, and can discourage these groups from seeking services. One of the benefits of integration is that it enables the delivery of services to all individuals who are at risk— whether or not they identify themselves as members of key populations.

The Kenya TB policy recognizes the cost-effectiveness of integrating TB services with HIV services:

The close association between TB and HIV makes it imperative to develop strategies for the delivery of combined TB and HIV services in what is commonly referred to as TB/HIV collaborative activities. These activities are aimed at coordination of TB and HIV programs at all levels, reducing the burden of TB among PLHIV and reducing the burden of HIV in TB patients. (MOH, 2013a, p. 46)

Integrated HIV counseling and testing is likely to cost less than stand-alone services, although evidence on the comparative costs savings is limited. In addition, little is known about the most efficient model of integration, the efficiency gains from integration beyond the service level, and any economic benefit to HIV service users (Sweeney, Obure, et al., 2011).

The MOH policy on Integrating the Management of STIs/RTIs into reproductive health services notes that the 1994 International Conference on Population and Development, in which Kenya was represented, emphasized controlling STIs and reproductive tract infections through existing maternal and child health and family planning services:

Thus, the ... conference viewed integration of services as one of the best means to increase access to Sexual and reproductive health (SRH) services. (MOPHS and MMS, 2010a, p. ii)

Nevertheless, STI control activities in the country remain weak, under-resourced, and under-used (MOPHS and MMS, 2010).

A critical component of integration is the cross-sectoral training of prison, law enforcement, and healthcare providers on the needs of key populations and ethics and human rights, such as informed consent, confidentiality, and avoiding stigma and discrimination. With proper policies, training, and supervision, a broad spectrum of public officials and services can be engaged in the health and well-being of MSM, TG, SWs, and PWID.

14. HIV Counseling and Testing

The policy on HCT—National Guidelines for HIV Testing and Counselling in Kenya—guarantees state funding of these services, explicitly provides them to MSM and SWs, and also authorizes a model for integrated services. The policy calls for “equitable access to HIV testing and counselling” for key populations in Kenya (NASCO and MOPHS, 2010b, p. ix). It defines key populations as prisoners, SWs, MSM, and PWID (NASCO, 2010, p. 15). Like pre-2010 Constitution policies, this one does not include TG in its scope.

Although the government does not support all stand-alone HCT clinics, which are largely funded by nongovernmental actors (NASCO and MOPHS, 2010b), the policy seems to suggest that such clinics are best suited to key populations, including PWID, youth, and other people with special needs, such as those living with disabilities. However, the policy fails to mention whether MSM too can be provided services through these facilities:

Stand-alone HTC [HIV testing and counseling] centres are facilities within the community that are not attached to other specific health services. Generally, these sites are operated by nongovernmental organisations (NGOs), faith-based organisations (FBOs), or other community-based organisations (CBOs), though the Government of Kenya (GoK) does provide support to some stand-alone HTC sites. Stand-alone HTC centres target the general population, or can also be tailored to populations with specific needs such as HTC for the deaf, youth-friendly HTC centres, and sites specifically available for commercial sex workers (CSW) and injecting drug users (IDU). (NASCO and MOPHS, 2010b, p. 8)

The policy also addresses the need to provide a stronger link to care and treatment programs for PLHIV, but it fails to provide guidance on how this is to be done for key populations, particularly those who prefer stand-alone clinics (NASCO and MOPHS, 2010b). It does, however, give guidance on referrals:

Clients or patients who present with specific diseases and conditions should be referred for appropriate services, such as tuberculosis (TB) management, prevention of mother-to-child transmission services (PMCT), STI management, or comprehensive care. When appropriate, HIV positive clients and patients may also be referred for additional counselling services that are beyond the scope of the HTC service provider. (NASCO and MOPHS, 2010b, p. 18)

The draft Kenya Prison HIV and AIDS Policy also provides for voluntary HIV and TB screening for prisoners and discourages compulsory testing, which it describes as counterproductive. But the policy fails to provide mechanisms for integrating HCT into treatment and care for those prisoners found to be HIV-positive (Kenya Prisons Services, 2006).

HCT-related policies also fail to identify mechanisms to involve PWID, MSM, SWs, or TG in the development of HCT protocols, in monitoring HCT, and in the monitoring and evaluation of HCT programs.

National Guidelines for HIV Testing and Counselling in Kenya does not mention saliva-based tests but rather enzyme-linked immune sorbent assays (ELISA or EIA), polymerase chain reaction, western blot, or viral culture tests, among others. However, it recognizes the need to adopt new HIV testing

technologies as they become available. This policy also provides for confidential testing and has details on how and when disclosure can take place. It states that HIV testing should not be a condition for receiving public goods or employment. Although the policy does not identify consequences for nondisclosure to a sexual partner of one's status, it does say: "Refusal to notify a sexual partner that one is HIV positive is an infringement on the right to health and wellbeing of the sexual partner (NASCO and MOPHS, 2010b, p. 25)."

National Guidelines for HIV Testing and Counselling in Kenya identifies three components of HCT: pre-test counseling, testing, and post-test counseling. It also allows for an opt-in /opt-out approach to HCT in healthcare settings.

Health care workers should feel empowered to test all patients except those that opt out and others that may be available for testing – spouses or other sex partners, children, parents, or other family members. (NASCO and MOPHS, 2010b, p. 11)

15. Antiretroviral Treatment

Guidelines for Antiretroviral Therapy in Kenya (fourth edition, adopted in 2011) is the country's policy governing the management of antiretroviral therapy (ART). This policy recognizes the enormous challenge posed by HIV treatment. However, it fails to guarantee provision of ART free of charge to anyone in Kenya, including MSM, PWID, TG, and SWs. It does mention the various health financing options that exist in the country, such as medical insurance schemes and the National Health Insurance Fund, and directs care providers to guide their clients on appropriate strategies (NASCO and MMS, 2011, p. 181).

The policy recognizes that key populations may not always be able to access services but calls only for additional mobilization strategies and prevention education.

The MOH has identified the most-at-risk populations to HIV infection in Kenya. This population should be targeted with preventive messages. In addition, the youth and other population groups such as sex workers may not always have access to HIV care and treatment services due to factors such as societal perceptions including stigma, service hours and friendliness of the service. (NASCO and MMS, 2011, p. 180)

The policy does not discuss how treatment challenges for key populations should be addressed.

Laboratory testing is required before ART begins. The policy states that people with mild cases of HIV (WHO clinical stage two) should be treated. It also mentions that adherence and associated psychosocial support and counseling are central to ART's success.

The policy also recognizes that PWID, SWs, and MSM constitute a significant proportion of PLHIV.

Transmission of HIV in Kenya is predominantly among heterosexual partnerships including stable partnerships. Transmission among other key populations at risk of HIV exposure, such as sex workers, men who have sex with men (MSM) and injecting drug users (IDUs) accounts for about 30% of all infections. Vertical transmission also remains an important mode of transmission of HIV in Kenya. (NASCO and MMS, 2011, p. 8)

Unfortunately, it does not call for ART initiation and adherence counseling that specifically addresses the needs of SWs, PWID, TG, or MSM, whose treatment is prone to interruptions as the result of legal proceedings, stigma, and violence.

Although the policy does not restrict access to ART by people in detention, it is silent on their eligibility. It also does not specify if those with past or present drug use are eligible for ART, but recommends avoidance of alcohol, recreational drugs and substances, and over-the counter and herbal

medication. The policy also recommends treatment for HIV and TB and for HIV and hepatitis B coinfection, regardless of the stage of the infection (NASCOP and MMS, 2011, p. 75)

The policy recognizes the fact that substance and alcohol dependence are common conditions among PLHIV and that these conditions, besides harming quality of life, can cause nonadherence to prophylactic and ART regimens as well as undermine safer sex practices, and should therefore be avoided. The policy also mentions the fact that TB and HIV, alcoholism, and hepatitis B or C coinfection are likely to increase the risk of hepatotoxicity (NASCOP and MMS, 2011, p. 46).

The policy does not have ART treatment and adherence protocols specific to any segment of the key populations, including MSM, PWID, or TG. However, it states that those with ongoing risk should receive intensive counseling to reduce risky behavior and should have easy access to condoms. It also says that SWs should be assessed for STIs more frequently and offered syndromic therapy when tests are positive (NASCOP and MMS, 2011, p. 23).

16. Tuberculosis Services

According to the National Tuberculosis, Leprosy and Lung Disease Unit of the MOH, tuberculosis is a major cause of morbidity and mortality in Kenya, affecting all age groups but chiefly people between the ages of 15 and 44 (MOH, 2014).

Kenya has a large TB disease burden and is ranked 15th among the 22 high burden countries that collectively contribute about 80% of the world's TB cases. The TB case notification rate (CNR) rose from 51 to 338 per 100,000 populations between 1987 and 2007 and is currently on a slow decline. As in the rest of Sub-Saharan Africa, the large increase of TB is attributed primarily to the Human Immunodeficiency Virus (HIV). (MOH, 2013a, p. iv)

The country's TB policy—Guidelines for Management of Tuberculosis and Leprosy in Kenya (MOH, 2013)—makes drugs available in many treatment settings at no charge:

Tuberculosis drugs are available and free of charge at any government health facility, most mission hospitals and some private health facilities. (MOH, 2013a, p. 25)

The country's policy for drug-resistant TB—Guidelines for the Management of Drug Resistant Tuberculosis in Kenya (MOPHS, 2010)—recognizes that settings where people gather can be high-risk sites for TB infection. It therefore requires that ventilation standards should be observed especially in prisons and remand cells, informal settlements (slums), and public transport (*matatus*) (MOPHS, 2010, p. 23).

While the TB and HIV guidelines do not specifically provide for PWID, they recognize the need for situational analyses to guide TB/HIV collaborative activities:

Situational analysis should include description of groups within the district considered to be at special risk of TB and/or HIV infection e. g. groups of people known to be infected with HIV and PLHA support groups, patients with STI's, prisoners, the military, CSW, IDU's and migrant groups like seasonal labourers. (MOH, 2006a, p. 13)

Guidelines for the Management of Drug Resistant Tuberculosis in Kenya requires the integration of TB and HIV activities as well as prevention and control of multidrug resistant TB. It recognizes the need to address the unique situations faced by prisoners, refugees, and other high-risk groups (MOPHS, 2010, p. 9). The link between TB and HIV is noted in the policy:

The HIV infection exponentially increases the risk of TB in co-infected individuals. TB on the other hand is a leading cause of morbidity and mortality among PLHIVs. HIV infected individuals are more likely to suffer acute opportunistic infections and develop drug reactions and therefore call for close attention. Thus all patients presenting with signs and symptoms of any of the two

diseases should be actively screened for the other and managed appropriately. . . . The close association between TB and HIV makes it imperative to develop strategies for the delivery of combined TB and HIV services in what is commonly referred to as TB/HIV collaborative activities. These activities are aimed at coordination of TB and HIV programs at all levels, reducing the burden of TB among PLHIV and reducing the burden of HIV in TB patients. (MOPHS, 2010, p. 46)

Kenya has adopted a TB control strategy based on the six elements of the WHO STOP-TB Strategy, including outpatient “directly observed treatment, short course,” or DOTS (MOH, 2006, p. 9).¹ Unfortunately, although guidelines recognize that prisoners are at higher risk of TB acquisition and transmission, they do not mention injecting drug use as a risk factor:

TB is spread more readily in congregate settings such as prisons, remands, informal settlement, and public transport. This is because of the long duration of potential exposure, crowded environment, poor ventilation, and limited access to health care services. (MOH, 2013a, p. 78)

17. Hepatitis Services

Kenya does not have dedicated policy guidelines on the management and control of hepatitis. However, the National Infection Prevention and Control Guidelines for Health Care Services in Kenya (MOPHS and MMS, 2010b) has a section on viral hepatitis and risk of transmission for health care workers in the workplace, at accident scenes, and so forth.

The Standard Operating Procedures for Needle and Syringe Exchange Programmes policy also indicates the risk of hepatitis B associated with sharing of needles and syringes (NASCOP and MOPHS, 2013c, p. 41). This policy provides justification for the NSPs in the country:

Government and non-government organisations provide Needle and Syringe Exchange Programmes to prevent the spread of HIV and Hepatitis C infections. (NASCOP and MOPHS, 2013c, p. 41)

18. Opiates Substitution Therapy

Substitution maintenance therapy has proven effective in terms of retention in treatment, reduction of drug use, improvement of psychological and social functioning, and reduction of high-risk injecting and sexual behaviours. As such, substitution maintenance therapy should be given serious consideration not only as an HIV prevention measure, but also for individuals with opioid dependence who are already infected with HIV, so as to minimize the risk of further transmission of the virus and to stabilize their underlying condition. (WHO, 2004b, p. 24)

All types of evidence-based treatment available in the community should be accessible in prisons, especially [opiates substitution therapy] for opiate-dependent people. In countries in which methadone or buprenorphine maintenance is available to opiate-dependent individuals in the community, this treatment should also be available in prisons. Prisoners on methadone or buprenorphine maintenance prior to imprisonment should be able to continue this treatment while in prisons and new treatments should be initiated for drug dependent inmates who may not have had access to treatment in the community. (UNODC, 2010)

¹ WHO’s strategy aims to provide high-quality diagnosis and patient-centered treatment to all TB patients by 2015. Its six elements are to address TB-HIV, multidrug-resistant TB, and the needs of poor and vulnerable populations; contribute to health system strengthening based on primary health care; engage all care providers; empower people with TB and communities through partnership; enable and promote research; and pursue high-quality DOTS expansion and enhancement. DOTS, in turn, has five components: political commitment with increased and sustained financing; case detection through quality-assured bacteriology; standardized treatment with supervision and patient support; an effective drug supply and management system; and a monitoring and evaluation system and impact measurement.

Kenya has three policy guidelines that speak to PWID. These are the Kenya National Guidelines for the Comprehensive Management of the Health Risks and Consequences of Drug Use (NASCO and MOPHS, 2013a), Standard Operating Procedures for Medically Assisted Therapy for People Who Use Drugs (PWUD) (NASCO and MOPHS, 2013b), and Standard Operating Procedures (SOP) for Needle and Syringe Exchange Programmes (NSEP) for People Who Inject Drugs (PWID) (NASCO and MOPHS, 2013c). Narcotic Drugs and Psychotropic Substances (Control) Act, No. 4 of 1994 (GOK, 2012 [1994]) is also an important document for PWID.

Policies in Kenya allow for the use of methadone and buprenorphine, thereby making MAT legal in Kenya for the management of people who are dependent on opioids.

In Kenya, MAT for opioid dependence will include: methadone, buprenorphine, naltrexone plus other medications for detoxification such as clonidine. MAT is more effective when combined with psychosocial support plus other interventions. (NASCO and MOPHS, 2013b, p. 11)

The policies also provide for NGOs to engage in opiates substitution therapy (OST) and provide for outpatient centres including pharmacies:

To increase access to MAT services there is need to extend opioid dependence treatment services to day care facilities or outpatient clinics plus pharmacies of selected public and NGO health facilities. This will enable opioid dependent persons to access OAMT through same day or walk-in appointments while pursuing employment or other personal engagements. (NASCO and MOPHS, 2013b, p. 34)

Both the Kenya National Guidelines for the Comprehensive Management of the Health Risks and Consequences of Drug Use and the Standard Operating Procedures for Medically Assisted Therapy for People Who Use Drugs state that eligibility for OST and initiation of the therapy are to be decided by the healthcare provider and client (NASCO and MOPHS, 2013a, p. 13; NASCO and MOPHS, 2013b, p. 17).

Unfortunately, these policies do not adequately address the issue of funding for OST. While the policy on MAT mentions funding as a necessary issue in the monitoring indicators (NASCO and MOPHS, 2013b, p. 41), it fails to guarantee long-term funding to sustain MAT, or even to consider the challenges related to such funding. Thus, although the MAT policy says that MAT services should be affordable for people who need them and preferably be free of charge (NASCO and MOPHS, 2013b, p. 12), it fails to discuss how that will be done or sustained.

Policy prohibits initiation of MAT for prisoners but allows those enrolled in the therapy before they were incarcerated to continue it (NASCO and MOPHS, 2013b, p. 47). The policy recognizes that female drug users—particularly those who are pregnant or breastfeeding—have numerous unmet basic needs and can face biomedical challenges (NASCO and MOPHS, 2013b, p. 46).

Withdrawal from treatment can be done if patients are violent or are threatening the safety of other patients and staff. The MAT policy discusses how to manage cessation of treatment, advising that this is best done voluntarily and with flexibility as doses are progressively decreased (NASCO and MOPHS, 2013b, p. 55).

19. Needle and Syringe Programs

Legislation related to needles and syringes, e.g., paraphernalia laws that penalize injecting drug users and drug-dependent persons carrying their own clean injecting equipment, as well as penalizing health and outreach workers who make such equipment available, can be an important barrier to HIV control among injecting drug users. (WHO, 2004c, p. 2)

The most relevant policy documents for the management of NSPs are Standard Operating Procedures (SOP) for Needle and Syringe Exchange Programmes (NSEP) for People Who Inject Drugs (PWID)

(NASCOP and MOPHS, 2013c) and the Narcotic Drugs and Psychotropic Substances (Control) Act, No. 4 of 1994 (GOK, 2012 [1994]). The standard operating procedures for NSPs observes:

Legislation against possession of needles and syringes for illicit drug use has been amended to allow the operation of NSEP in order to reduce the spread of HIV and other blood borne diseases in Kenya. (NASCOP and MOPHS, 2013c, p. 41)

Indeed, the Narcotic Drugs and Psychotropic Substances (Control) Act, as revised in 2012, says that the law on possession “shall not apply to a person authorized under the [penal code] regulations to be in possession of the narcotic drugs or psychotropic substances” (GOK, 2012 [1994], p. 11).

The NSP standard operating procedures cover only NSP outlets—fixed-site facilities and pharmacies—that the MOH has authorized. They do not allow dispensing machines but do authorize NSP outreach workers to provide needles and syringes to PWID (NASCOP and MOPHS, 2013c, p. 13).

The policy dictates nationwide coordination and funding of NSPs (including the provision of stock and the collection and disposal of used sharps) through NASCOP (NASCOP and MOPHS, 2013c, p. 36).

Although the policy does not explicitly refer to TG services, it recommends the hiring of TG staff in areas where NSPs provide services to TG (NASCOP and MOPHS, 2013c, p. 24).

The policy mentions the need for NSP centers to provide information and referrals to ensure continuity of care, including availability of other services such as male and female condoms, condom-compatible lubricants, and HIV, hepatitis B and C, TB, and OST services. It adopts the international definition of NSPs:

NSEPs form part of a comprehensive package of nine interventions recommended in the WHO, UNODC, UNAIDS Technical Guide to address injecting drug use and HIV. . . . Additional services for women may also include sexual and reproductive health and prevention of mother-to-child transmission of HIV. (NASCOP and MOPHS, 2013c, p. 5)

The policy defines an exhaustive minimum package for NSP kits (NASCOP and MOPHS, 2013c, p. 20) but does not exempt from liability those with only trace amounts of drugs. This omission is serious, because the policy can be seen as failing to protect centers that lack MOH’s official approval to operate. Only authorized centers are protected from prosecution for possession of equipment or utensils for use in connection with narcotic drugs or psychotropic substances.

20. Condoms and Lubricants

Correct and consistent use of condoms and water-based lubricants is strongly associated with a reduction in the risk of HIV transmission. Sufficient and appropriate (water- or silicone-based) lubricants must be available to reduce the risk of condom failure; among the barriers to access and utilization are cost, availability, and lack of knowledge (Beyrer, Wirtz, et al., 2011). Evidence also suggests that making condoms available free in a variety of settings is preferable to making them available only in stores.

Governments must have a strategy and policy for condom and lubricant procurement and distribution. However, appropriate condoms and lubricants are often not available or are inadequately distributed to key populations, leading members of these groups to engage in unprotected sex. Community groups can play an important role in the distribution of condoms, including social marketing. However, the police often cite carrying and using condoms as evidence of intent to solicit sex work (Joint United Nations Programme on HIV/AIDS and ATHENA Network, 2011, p. 17).

Among Kenya's policy documents on condoms are the National Condom Policy and Strategy (MOH, 2010) and KNASP III (NACC, 2009). The condom strategy recognizes that condom needs and preferences are not uniform in the Kenyan population, and that it is therefore important to offer condoms free of charge while also charging those who can afford to pay. The strategic plan says that water-based lubricants should be included in the procurement plan for prevention commodities (NACC, 2009, p. 48).

Other more recent policy documents, such as the standard operating procedures for NSPs (NASCOP and MOPHS, 2013c, p. 7), Standards for Peer-Education and Outreach Programs for Sex Workers (MOH, 2010, p. 10), and National Guidelines for HIV/STI Programs for Sex Workers (NASCOP and MOPHS, 2010a, p. 15), not only mention water-based or condom-compatible lubricants, but also list them as part of the essential packages.

National Guidelines for HIV/STI Programs for Sex Workers says that services for SWs should be free or affordable (NASCOP and MOPHS, 2010a, p. 30) and available without interruption:

Service providers need to ensure an adequate and uninterrupted supply of male and female condoms and water-based lubricants. Any health services provided to sex workers must be in line with international standards, current best practices and guidelines within the country. (NASCOP and MOPHS, 2010a, p. 30)

To increase access, the government aims to strengthen the system of waivers and exemptions for maternal and child health and STI services, including provision of free condoms to the most vulnerable groups: key populations, the poor, and youth. Public institutions are allowed to levy affordable charges on name-brand condoms through the private sector (NASCOP and MOPHS, 2010a, p. 13).

Unfortunately, none of the policy documents provides for the procurement of condom-compatible lubricants. Stakeholders reported in interviews on the results of this decision model that the government, with the support of a donor agency, had procured water-based lubricants and was distributing them to MSM community-based groups, but respondents felt that this initiative's sustainability and scalability were not guaranteed in the absence of a policy to support them (see the first section of the appendix).

21. Sexually Transmitted Infections

In addition to being a valid human right and health concern, treatment of STIs is critical in halting the spread of HIV infection. In Kenya, STIs are covered by National Guidelines for Reproductive Tract Infection Services (MOH, 2006b), Management of Sexually Transmitted/Reproductive Tract Infections: National Orientation Package for HIV Services Providers (MMS and MOPHS, 2009), and National Strategy on HIV and AIDS and STI Programming along Transport Corridors in Kenya (MOH, 2013). Other policies of interest in the management of STIs in Kenya are the Public Health Act (GOK, 2012 [1986]), National Infection Prevention and Control Guidelines for Health Care Services in Kenya (MOPHS and MMS, 2010b), and the Penal Code (GOK 2012 [2010]). A review of current policies shows that little is being done to take into account oral and anal STIs and such coinfections as hepatitis B and C. Sex workers, men who have sex with men, and transgender people may not feel comfortable attending general STI clinics and therefore require specialized services.

National Guidelines for Reproductive Tract Infection Services states that management of symptomatic STIs should be effective and should follow the syndromic management guidelines for STI/RTI case management (MOH, 2006b, p. 45). The syndromic approach uses clinical algorithms or flow charts developed for each of the commonly presenting syndromes in STIs, which represent a combination of practical and scientific information necessary for decision making (MOH, 2006b, p. 54). The guidelines also provide options for presumptive treatment for adults and children (MOH, 2006b, pp. 62, 74, 75).

However, these guidelines as well as National Guidelines for HIV/STI Services for Sex Workers (NASCOP and MOPHS, 2010a) are silent on authorizing pharmacists and other providers of informal healthcare to deliver periodic presumptive treatment for STIs.

Although the Public Health Act does not discuss voluntary screening, it does address the consequences of not seeking treatment:

It shall be the duty of every medical officer of health in his official capacity and of every Government medical officer and district surgeon who knows or has reason to believe that any person is suffering from any venereal disease in a communicable form and is not under treatment by a medical practitioner or is not attending for medical treatment regularly and as prescribed by such medical practitioner to give notice to such person of the requirements of this Act in regard to attendance for treatment of persons suffering from venereal disease, and, if thereafter such person does not comply with those requirements, to report the matter to the magistrate. (GOK, 2012 [1986], p. 24)

In order to harmonize STI policies in Kenya, NASCOP is drafting National Guidelines for Key Population HIV/STI Programming. The draft policy provides free services for key populations who cannot afford to pay. It includes detailed algorithms to guide provision of services to meet the specialized needs of SWs, PWID, and MSM. It also addresses services for viral hepatitis not only for PWID but also for MSM.

Although the draft policy does not provide expedited treatment of partners, it takes a public health approach to contact tracing and presumptive treatment for sexual partners. The policy also allows a person diagnosed with an STI to hand-deliver treatment drugs to their sexual partner(s), who may not be able to come to a facility for treatment.

When the policy becomes official, it will need to be integrated into other, higher-level policy documents such as the Health Sector Strategic Plan 2013–2017, the Public Health Act, Vision 2030, and medium-term plans for the health sector.

22. HIV Prevention Outreach

Outreach activities increase access to community- and facility-based programs and also the use and impact of these programs. Outreach through networks, communities, and peer educators is often the best and sometimes the only way to reach populations who may be forced to hide their behavior and are afraid to access regular services.

It is important to involve marginalized communities in mobilization for HIV prevention, care, and treatment (United Nations Development Programme, 2009; Joint United Nations Programme on HIV/AIDS and ATHENA Network, 2011). Because most of these populations are invisible or hidden, they are difficult to reach with services. Stigma and discrimination can be significant barriers to accessing services. Therefore, community outreach is a critical part of HIV program intervention strategies and should be included in HIV policy and guidelines. There should also be sufficient resources for these strategies.

Kenya has no specific policies on community outreach, but such outreach is discussed in most service-oriented policies for key populations, including the national guidelines on HIV testing and counseling in Kenya. The guidelines define outreach as follows:

Outreach HTC refers to services offered outside of a fixed site, such as mobile or workplace HTC. Some of the current means that are used for providing outreach HTC services in Kenya include:

- *Vehicle with private counselling rooms*
- *Using tents as counselling rooms*

- *Utilizing pre-existing community facilities such as a church, school, university, or market building*
- *In the workplace*
- *Or a client or patient's home*
- *Camel or bicycle, or other mobile outreach mechanism*

Outreach HTC can be conducted at night to reach working populations, including taxi and truck drivers and sex workers who are more available for HTC at night. This is sometimes referred to as moonlight HTC. (NASCOP and MOPHS, 2010b, p. 9)

23. Information, Education, and Communication

Information, education and communication (IEC) activities play a key role in raising awareness of the HIV epidemic as well as prevention methods, behavior change, treatment, and other issues. Well-conceived IEC strategies and methods are important in achieving desired levels of behavior change and in increasing the uptake of condoms, HCT, and treatment. Involving community members in designing and delivering IEC material is essential, because identities and risk behaviors can be extremely heterogeneous across MSM, PWID, TG, and SW groups.

In general, IEC materials do not focus on key populations. Policies focusing on SWs and PWID speak of the need to provide information on HIV services and risk reduction but are not explicit about developing IEC materials (NASCOP and MOPHS, 2010a; NASCOP and MOPHS, 2013a). Materials for PWID, TG, MSM, and SWs were developed by NGOs and NACC has endorsed them. NASCOP is currently developing standardized IEC materials for key populations. Because Kenya has no policies budgeting publication and distribution, NASCOP may eventually have to rely on donor funding for this.

A draft Key Populations (MARPS) Communication Strategy 2013–2017 identifies IEC strategies and information specific to SWs, PWID, and MSM but not for TG who are SWs and/or have sex with men (MOH, unpublished). The strategy does not place any restrictions on IEC content related to MSM, PWID, TG, or SWs on the basis of public decency or morality. For prisoners and persons in detention settings, only information on biomedical interventions and on mitigating and managing sexual violence is provided (MOH, unpublished, p. 21).

Kenya needs to develop guidelines or update existing policies to ensure that IEC materials are sufficiently detailed and cover all relevant issues, such as fewer partners, condom use, and biomedical interventions. Such guidelines should also ensure that IEC materials are developed with participation by relevant communities.

24. Alcohol and Substance Abuse Harm Reduction

Given the linkage between alcohol and substance abuse and high-risk behaviors, policies dealing with alcohol and substance abuse will invariably have an impact on HIV services to key populations. Alcohol, drug use, and violence in some settings may further exacerbate their vulnerability and risk (WHO, 2012).

The Alcohol Drinks Control Act, 2010 (GOK, 2007, p. 11), NACADA Strategic Plan 2009-2014 (NACADA, 2009), Guidelines for Implementing and Enforcing the Alcohol Drinks Control Act, 2010 (Office of the President, 2011), National Standards for Treatment and Rehabilitation of Persons with Substance Disorders (NACADA, 2010), and the Constitution of Kenya (GOK, 2010) are the key policy and legal documents on alcohol and substance abuse in Kenya. However, none of them mentions a need for special focus on MSM, PWID, TG, or SWs.

National Standards for Treatment and Rehabilitation of Persons with Substance Disorders provides “education programs for students, commercial sex workers, long distance truck drivers and other vulnerable groups” (NACADA, 2010, p. 16) but not for PWID, MSM, and TG. Although it integrates HIV services in treatment centers for alcohol dependence, it does not provide funding. The standards do allude to the need for public subsidy of treatment and rehabilitation centers, directing that:

Clients seeking treatment and rehabilitation services get value for their money and the services rendered to them are cost-effective. (NACADA, 2010, p. xi)

These guidelines also acknowledge the need to integrate HIV education in treatment and rehabilitation programs:

Health education about the dangers of concurrent alcohol/substance Use and ART (e.g. toxicity, compounded immune suppression, noncompliance) and the risk of unprotected sex in the transmission of the HIV and development of ARV drug resistance. Regardless of HIV status, injection drug users are informed about harm reduction techniques and safe injecting practices to reduce the risk of contracting or transmitting the virus. (NACADA, 2010, p. 39)

Unfortunately, the guidelines are too general to provide for detailed analysis of the needs of key populations. In reference to prisoners, for example, the guidelines fail to recognize unique challenges faced by prisoners and borstal institutions that might require harm reduction interventions.

25. Sexual and Reproductive Health and Rights

Restrictive laws and policies can pose major barriers that keep key populations from accessing high-quality contraceptive services and realizing their reproductive rights. For example, in India, women under the age of 18 are denied family planning (FP) services. In Bangladesh, despite improvements in the policies for married women, unmarried women are officially prohibited from receiving some popular and effective contraceptive methods, such as injectables and implants. These types of policies present real challenges for women such as SWs, many of whom are young or unmarried (Petruney, Noriega Minichiello, et al., 2012).

Ensuring complementary legal and policy frameworks that support linkages between HIV and SRHR services improves access to and uptake of these services and helps to address stigma and discrimination for underserved, vulnerable, and key populations. Integration of services can include everything from coordinated information and referral to provision of comprehensive, on-site services (Collins, Lusti-Narasimhan, and Osborne, 2011).

Kenya Health Sector Strategic and Investment Plan (MOH, 2013), National Reproductive Health Policy (MOH, 2007), National Reproductive Health Strategy 2009-2015 (MOPHS and MMS, 2009b), Adolescent Reproductive Health and Development Policy (MOH and Ministry of Planning and National Development, 2005), and the National Family Planning Costed Implementation Plan 2012 – 2016 (MOPHS and MMS, 2012) are Kenya’s main policy documents on SRHR.

In 2012, KNCHR conducted a study to establish the extent to which the country had attained SRHR for her citizens. The report noted that SRHR are rooted in Kenya’s international, regional, and national legal commitments, even if fulfilment of these commitments is “progressive.”

These international, regional and national instruments place an obligation on the state to respect, protect, and fulfil the sexual and reproductive health rights of all Kenyans by ensuring that essential services are available, accessible, acceptable and of good quality. The State is obligated to fulfil SRHR ‘progressively’, depending on the available resources. This requires it to demonstrate ‘measurable progress towards the full realisation of the SRHR and to refrain from adopting ‘regressive measures’. The State is further obligated to fulfil those rights that require immediate realisation such as freedom from discrimination and freedom to control one’s health and body. (KNCHR, 2012, p. xviii)

Unfortunately, most SRHR policy documents appear not to recognize key populations. Indeed even the current Kenya Health Sector Strategic Plan mentions sex workers only among other “at risk populations”—a concept of risk that is not in concurrence with HIV policy documents.

At risk populations—Health Workers, Commercial Sex Workers, women, persons with disability, elderly, children, youth, marginalized, religious/cultural communities. (MMS and MOPHS, 2013, p. 32)

Although the condom policy recognizes the need for “provision of condoms free of charge to the most vulnerable groups” (MOH, 2001, p. 14), it does not explicitly refer to SWs, MSM, PWID, or TG populations. The National Reproductive Health Policy identifies funding as an ongoing challenge for program implementation in Kenya.

The National Reproductive Health Strategy, 1997-2010, has been guiding implementation of the reproductive health programme but has faced a number of challenges, especially inadequate funding. (MOH, 2007, p. 1)

Given funding constraints, key populations are likely to suffer when policy documents do not specially mention their SHRH needs.

Like the condom policy, the National Reproductive Health Policy does not mention SWs, PWID, TG, or MSM. Moreover, it says that policy guidelines must be applied within the confines of the law:

Reproductive and sexual health rights, within the context of the law, are components of human rights. (MOH, 2007, p. 3)

This phrasing denies SRHR to key populations, whose behaviors that put them at risk of acquisition and transmission of HIV are in conflict with the law.

The policy on contraceptives allows emergency contraception but fails to provide accessible and safe abortions. This could be because abortion is criminalized in Kenya.

Emergency contraception (EC) refers to the use of certain contraceptive methods by women to prevent pregnancy after unprotected sexual intercourse. Hormonal ECPs must be taken within 120 hours of intercourse, however, the sooner they are taken, the more effective they are. ECPs provide a second chance for preventing pregnancy after unprotected sex, either accidental or coerced sex, or rape. (Division of Reproductive Health, MOPHS, 2010, p. 103)

CONCLUSION

According to available data, about 30 percent of all new HIV infections occur in key populations. Notwithstanding this high figure, evidence suggests that Kenya is making significant progress in HIV prevention, treatment, and care programming for these groups. Moreover, policy documents enacted after Kenya adopted its Constitution in 2010 have expanded human rights protections, increased public participation in policy development and implementation, and incorporated internationally recommended standards for HIV policies for key populations.

However, the endemic challenges of stigma and discrimination, verbal and physical violence, limited access to HIV and health services, and criminalization still hinder HIV prevention, treatment, and care services for Kenya's key populations. Although policies are increasingly progressive, their impact is weakened by laws criminalizing MSM, SWs, and PWID. A growing international consensus holds that decriminalizing sex work and homosexuality is an essential part of a comprehensive public health response to the elevated risk of HIV acquisition and transmission among SWs and MSM. Employing nonpunitive harm reduction and drug-dependence treatment programs has also been effective in reducing HIV transmission among PWID and improving this group's adherence to HIV treatment.

The elevated HIV acquisition and transmission risk among key populations has also spurred development of HIV intervention policies for those populations. These policies are welcome, but the trend could lead to a system of vertical programs rather than integrated ones that guarantee sustainability and mainstreaming. It is necessary, then, for the overarching health and HIV policy environment to be comprehensive and to integrate—and scale up—the biomedical, behavioral, and structural HIV responses that key populations need.

Finally, it is necessary for policies in Kenya to deepen and strengthen the culture of stakeholder participation in policy development, implementation, and evaluation, as the new Constitution requires. In this way, synergies among programs will grow, supporting interventions that take into account the unique needs of each key population.

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APPENDIX: SUMMARY OF STAKEHOLDERS' REVIEW OF ASSESSMENT FINDINGS

An important part of the decision model analysis was presentation of its preliminary findings to key populations, in order to assess the impact of Kenya's existing policies on these groups. To that end, the Health Policy Project and NACC convened three stakeholder meetings: one with MSM, one with SWs, and one with PWID.

At all three meetings, the audience was given an overview of the decision-making model. The presenter explained that the model is based on a policy analysis and advocacy decision model for HIV-related services for PWID. In 2012, African Men for Sexual Health and Rights adapted the model to cover policies affecting MSM, TG, and SWs, so that local advocates could use it to identify opportunities to improve policies governing public health services for these three key populations.

The presenter explained that the decision model compares the current policy environment in a country with international best practices. This reveals the extent to which current laws and policies support or restrict the implementation of services for key populations. The decision model also reveals gaps between policy and practice—in particular, instances in public health programs for key populations in which policy and practice are not aligned. Using the results of a policy analysis using the decision model, advocates can refine their priorities and strategies and foster country ownership of public health programs for key populations.

The presenter explained that the decision model for policies related to MSM, TG, and SWs had been implemented in only three countries, prior to Kenya: Burkina Faso, Togo, and Ghana. (There it was used to inform the Ghana National AIDS Policy.) Only in Kenya had the two decision models—for PWID and for MSM, TG, and SWs—been combined to consider policy for all four key populations. The presenter said that the stakeholder meetings had been called to validate the findings of this analysis.

Finally, in addition to responding to the findings, the audience was asked to consider if the decision model analysis had missed any policy documents, if policies in fact translate into implemented public health services, and whether the recommendations that the study team proposed were relevant to Kenya's key populations and appropriate for them.

Findings and Recommendations on Kenya's Policy Framework

The presenter explained that the national framework section of the decision model analysis looked at policies that enhance coordination, integration, planning, and budgeting of services for key populations.

Key findings:

- The majority of the ministerial policies do not explicitly mention areas of integration and coordination in health and social related services.
- General development plans do not refer to initiatives that address the needs of key populations.
- The majority of the health-specific programs mention the need for integration with other related health and social programs in community settings.
- The majority of the program policies are silent environments or circumstances where sex work/male to male sexual activity/drug use may take place.
- Many ministerial policies governing services fail to mention that these services should address the human rights of all key populations.

Key recommendations:

- Policies should explicitly prioritize community-led involvement of key populations and also state the right of key populations to universal access to services.
- Policies on key populations need to be integrated across sectors.

Reactions of MSM:

- There was discussion of how explicit policy should be with reference to MSM or other key populations. The audience felt a need to tread carefully, lest the decision model analysis's language and recommendations have a negative influence on the policy environment of key populations.
- The audience mentioned that from their own experience of the Kenya policy environment, as long as gender issues are defined according to male and female social constructs, such policies are guaranteed adoption. Challenging these norms, however, would create unnecessary resistance from the public.
- The audience proposed that instead of recommending that policies explicitly mention each key population, the team should recommend that policies mention key populations only in specific areas of concern.

Reactions of SWs:

- The audience felt that the phrase "explicitly prioritize" in the first recommendation should be replaced with "strengthen."
- The audience felt that SWs are not fully engaged and their recommendations for service delivery are not embraced. They proposed that the study team make an additional key recommendation: that the SW community be engaged and involved throughout the cycle of public health projects. Such inclusivity, they said, should ensure that these projects are community-led.
- The audience mentioned the need for policy to be stated in a way that key populations can understand.
- The audience mentioned the need to state that the right of universal access extends to key populations.

Reactions of PWID:

- Minor as well as major policy documents should explicitly prioritize community-led involvement of key populations and also state that the right of universal access includes key populations.

Findings and Recommendations on Community Partnership

The presenter explained that this section of the decision model analysis considered whether the language of the policy documents reviewed included key populations in the design, implementation, and evaluation of programs.

Key findings:

- The policies exhibited a broad lack of specificity in calling for formal and regular mechanisms for active participation in decision making and in the policy and program cycle.
- The Global Fund Country Coordinating Mechanism and Kenya's policies governing national multisectoral HIV coordinating bodies require membership of MSM, TG, SW, and PWID or organizations representing these populations.

- Policy documents are silent on support for registration of NGOs representing MSM, TG, SWs, and PWID.

Key recommendations:

- Policies should be explicit about the community-led involvement of key populations in the policy and program cycle.
- Policy should explicitly support the registration of NGOs, inclusive of those made up of MSM, TG, SW, and PWID (in conformity with the Constitution and as evidenced by HIV data).

Reactions of MSM:

- The audience agreed with the findings. However, they pointed out that inclusion of MSM and other key populations in practice is lacking in the Global Fund's Country Coordinating Mechanism, which instead addresses PLHIV. This group, the audience said, does not necessarily represent the interests of key populations.
- The recommendation on registration of NGOs made up of MSM was highly praised as a matter of urgency. The audience mentioned that various MSM organizations have been denied registration, thus hampering the availability of high-quality services for MSM in Kenya.

Reactions of SWs:

- These stakeholders recommended replacing the word "inclusiveness" in the third recommendation with "community-led."
- With reference to the Global Fund, the audience recommended elaboration on who may represent a key population. They felt that usually the person representing a key population is not a person drawn from the key population. They recommended that key populations should elect their own representatives to present their needs and wishes in such forums.

Reactions of PWID:

- The audience agreed with the key findings. However, they discussed whether the report on the decision model analysis should speak of "key populations" or "vulnerable groups." Most people preferred "vulnerable groups" to either "key populations" or "most-at-risk populations" (MARPs).
- The audience said that the report's recommendations have to be stated in a way that is feasible and applicable.
- The audience expressed the need for a way to describe these vulnerable populations, because there are specific interventions for each population discussed.
- It was noted that the language of policy is never explicit; it's usually very general. Thus the recommendations should avoid calls for explicit language and instead should call for inclusive language.

Findings and Recommendations on Authorization

This section covered review of policies from the perspective of the legality of services and optimal oversight structures.

Key findings:

- The majority of the policies had clear guidelines on guarding the privacy of medical records of key populations.

- The policies offered broad language on general protection against deliberate transmission of infectious diseases.
- The policies offered broad provision for the integration of reproductive health services, including reproductive health research.

Key recommendations:

- Policy should provide clear guidelines to ensure that PLHIV are not criminalized on account of their health status.
- Public health policy should adopt language that is inclusive of key populations.

Reaction of MSM:

- The audience agreed with these findings and recommendations.

Reaction of SWs:

- The audience suggested an additional recommendation that policy on reproductive health services include key populations.

Reactions of PWID:

- The audience felt there was a need to tailor provision for specific populations in the recommendation given.
- The audience would have liked to have a list of the policy documents reviewed, showing the study team's recommendations for each document.

Findings and Recommendations on Informed Consent

This section covered informed consent as a protection for key populations participating in medical interventions.

Key findings:

- Policy compels those suspected of sexual crimes to undergo an HIV test.
- Policy calls for written consent for people under age to participate in a medical intervention.
- Policy makes broad provision for consent by human subjects of biomedical research.

Key recommendations:

- Policy should provide adequate protection for people in detention and prison settings.
- Overarching policy language is needed to provide protection for key populations.

Reactions of MSM:

- There was general discussion of protection in prison settings. What happens to the results of the tests conducted on prisoners upon entry to prisons and detention settings is unknown.
- It was noted that rape is a frequent occurrence in cells occupied by men. Prison policy documents need to include explicit measures for protection and treatment of rape victims and also punishment of the perpetrators.

Reaction of SWs:

- It was pointed out that organizations serving SWs often collect vital information on the health status of SWs that can be linked to their identity. This was considered a breach of confidentiality and has deterred many SWs from accessing the critical services of these

organizations. The audience said that the biometric technology that organizations use has loopholes that can lead to breaches of confidentiality.

Reactions of PWID:

- With regard to the first key finding, these stakeholders said that the report should recommend that HIV testing be done upon entry into detention or prison so that those who test positive can have better health outcomes.
- Policy should recommend provision of routine testing as part of VCT in prisons, just it is in the community. In this way HIV testing can be normalized for all.

Findings and Recommendations on Privacy And Confidentiality

This section covered findings and recommendations on the protection of data.

Key findings:

- Policies offer broad, general protections for the confidentiality of medical data, including risk assessments.
- Policies do not explicitly protect information regarding behaviors (sex work, MSM sexual activity, TG status, or drug use).
- Policies do not prevent medical, psychological, or drug dependence treatment data from being used in legal proceedings.

Key recommendations:

- Clarify that protections for risk-assessment data cover information on criminalized behavior that is obtained in the course of providing prevention, care, and treatment services.
- Prohibit the use of medical, psychological, or drug dependence treatment data to initiate or substantiate criminal charges.

Reactions of MSM:

- The audience felt that labeling people in terms of their criminalized behavior will expose them to harassment by the public and the police.
- The audience supported the recommendation that policy prohibit the use of medical, psychological, and drug treatment data to initiate or substantiate criminal charges.

Reactions of SWs:

- The audience reported that many sex workers have been accused by their clients of transmitting HIV. They said that national and local policies do not protect their profession and health information.

Reactions of PWID:

- The audience agreed with the findings and recommendations.
- They said that in practice they have little privacy and confidentiality. They asked for the decision model report to recommend public education on the right to privacy and education for service providers on the privacy of data.

Findings and Recommendations on Registries

This section covered findings and recommendations on the maintenance and transparency of lists of members of key populations.

Key findings:

- Policy calls for secure systems for storing protected data (medical and epidemiological data, for example).
- A broad lack of transparency exists in policies related to nonmedical or informal registries that may contain information on key populations (lists of SWs, MSM, and PWID, for example).

Key recommendation:

- Clarify and regulate the use of nonmedical or informal registries. Topics needing attention are the legality (or illegality) of such registries, public information about the existence and use of such registries, processes for removal from a nonmedical or informal registry, and data protections.

Reactions of MSM and SWs:

- Both audiences proposed removing from registries any language that depicts key populations, so that the term “key populations” may not end up on the criminal books, as is already the case for MSM and SWs.

Reactions of PWID:

- The audience agreed with the key findings and recommendations.

Findings and Recommendations on Stigma And Discrimination

This section covered findings and recommendations on the extent to which policies protect key populations from stigma and discrimination.

Key findings:

- Constitutional protections against stigma and discrimination do not explicitly cover sexual orientation, sex work, or gender identity.
- No policies provide legal remedies for customary laws, teachings, or practices that affect key populations.
- No policy prohibits incitement or public expressions of hatred, contempt, or ridicule of key populations or of drug dependency.

Key recommendations:

- Expand stigma and discrimination protections to explicitly cover sexual orientation, gender identity, sex work, and medical conditions such as drug dependency.
- Other relevant policies, especially those governing public health-related programs, should include explicit language protective of sexual orientation, sex work, gender identity, and drug dependency.

Reactions of MSM:

- The Constitution is broad and covers everyone. It does not need to explicitly mention key populations.
- The audience felt that the second finding listed—touching on customs affecting key populations—is not in itself a concern, because the Constitution is all-inclusive. They suggested a recommendation on the need for clear and explicit language on key populations in other policy documents.

- Policies—especially health policies—should explicitly protect key populations from stigma and discrimination. Linking this policy recommendation to public health will help advocates push for it.

Reactions of SWs:

- The audience suggested adding explicit language on sexual orientation, sex work, and gender identity to the recommendation on public health policies.
- In response to the second key finding, the audience said that the Kenya Constitution protects everyone from harmful practices.
- In response to the first recommendation listed, there was a suggestion to strike “sex work” and replace it with “nature of work.”

Reactions of PWID:

- The key findings should state that the Constitution protects everyone from stigma and discrimination, even though these protections are not enforced for everyone. They said that the study team should take this issue up, and push for the eradication of stigma and discrimination especially on behalf of vulnerable populations. The audience said that PWID should not be stigmatized; instead, they should be viewed as people who are ill and need help.
- The audience felt that SWs and PWID have received a great deal of acceptance in the past year as a result of efforts by key government institutions and advocacy groups.

Findings and Recommendations on Criminalization

This section covered the legal status of populations and behaviors.

Key findings:

- Policy distinguishes between possession of illegal substances for personal use and possession for trafficking.
- Policy does not define the amount of a substance that constitutes criminal liability for the possessor.
- Policy punishes same-sex sexual behavior with imprisonment.
- Sex work is not illegal, but soliciting and pimping are criminalized.
- Policy criminalizes transmission of HIV.

Key recommendation:

- Policies should protect access to medical treatment by sex workers.

Reactions of SWs:

- The audience mentioned the need to review the penal code for consistency with the Constitution.
- The audience proposed adding a recommendation to remove liability for HIV exposure and transmission unless willful and malicious intent can be proven.

Reactions of PWID:

- The audience felt there was need for a recommendation—addressing the second finding—that policies establish the quantities of drugs constituting possession for personal use and quantities constituting possession for trafficking. They suggested that the study team consult with the National Authority for the Campaign against Alcohol and Drug Abuse for this information.

- The audience felt that the term “people who inject drugs” is too narrow and should be abandoned. “People who use drugs” includes those who don’t inject drugs but use them in other ways.

Findings and Recommendations on Gender-based Violence

Key findings:

- Policies use inclusive language to recognize GBV directed against women and men.
- Policies recognize violence in detention centers.
- Policies do not specifically recognize key populations.

Key recommendations:

- Policies should use overarching language that recognizes the unique vulnerabilities of key populations to GBV (rape, for example).
- Policies should recognize service-specific needs of key populations exposed to or vulnerable to GBV.
- A consolidated GBV policy (under the National Gender and Equality Commission) needs to be enacted.

Reaction of MSM:

- The audience agreed with the findings and recommendations.

Reactions of SWs:

- The audience said that GBV policies need to provide explicit protection to sex workers. In practice, when SWs report GBV, law enforcers peg the GBV to the workers’ criminalized profession and do not give it the attention and weight it deserves. This prevents many SWs who go through GBV from reporting it.
- The audience also said that many health care providers at GBV clinics are not sensitive to the needs of SWs.

Reactions of PWID:

- The audience reported that GBV is rampant in prisons but not documented. They said that GBV increases the prevalence of HIV in prisons. They recommended that advocacy groups should push for the implementation of GBV policies in prison settings.
- The audience also recommended the need to strengthen protection from GBV in borstal institutions. For example, all prison settings including borstal institutions should provide such basic items as toothpaste and soap, because most instances of GBV occur when people struggle for these things.

Findings and Recommendations on Torture and Cruel, Inhuman, and Degrading Treatment or Punishment

Key finding:

- The Constitution protects everyone from torture and cruel, inhuman, and humiliating treatment.

Key recommendation:

- Policy should name sexual orientation, gender identity, nature of income, and health status, including injecting drugs, as classes protected from cruel and inhuman treatment.

Reactions of MSM, SWs, and PWID:

- All three audiences agreed with the finding and recommendation.

Findings and Recommendations on Human Rights

Key findings:

- The Constitution gives everyone the right to the highest attainable standard of health and to education, but policies do not specifically mention key populations.
- No policies incentivize supportive law enforcement practices to address violence against key populations.
- No policies cover the revision of gender on the identity documents of TG.

Key recommendations:

- Policies should specifically include key populations under broad constitutional protections.
- Policies should specifically mention protecting key populations from violence.
- A policy should be established for the acquisition of new identity documents by TG.

Reaction of MSM:

- The audience agreed with the findings and recommendations in this section.

Reaction of SWs:

- The audience felt that policies bearing on human rights did not need to name specific groups; references to “key populations” should be sufficient.

Reaction of PWID:

- The audience felt that human rights are a more pressing issue for TG. They said that the human rights of TG have been sidelined both in community and prison settings. They suggested that advocacy groups for TG should push the transgender human rights agenda in various forums. One example mentioned was the lack of washrooms, jails, and other facilities specifically designated for TG.

Findings and Recommendations on Procurement and Supply Management

Key findings:

- Policies on oversight bodies, forecasting, and quality and quantity monitoring are either silent on participation by NGOs or restrict their participation.
- Procurement policy gives priority to WHO's Prequalified Drugs List and its quality assurance and quality control standards for medicines and medical commodities.
- Kenya's essential medicines list does not include all of the WHO essential medicines.
- Kenya lacks explicit policies on the importation or local manufacture of WHO medicines for clinical use, nor do policies mention reduction in taxes or tariffs, distribution margins, or pricing parameters.
- Kenyan policy identifies mechanisms for key populations to be involved in the product selection of harm-reduction commodities.

Key recommendations:

- Policy should call for representation by key populations on oversight bodies and in forecasting and the monitoring of supply quality and quantity.
- Evidence-based guidance is needed on essential drugs and commodities (STI treatments, condoms and lubricants, and antiretroviral drugs).
- Policy is needed to provide a special mechanism for the distribution of commodities for key populations.

Reaction of MSM:

The audience agreed with the findings and recommendations in this section. In addition, they recommended county-level advocacy for key populations to participate in planning and budgeting.

Reactions of SWs:

- The audience mentioned that the third finding should specifically reference STI drugs, ART drugs, lubricants, and condoms.
- The audience proposed adding a recommendation for fast procurement and distribution of condoms at the county level.
- The audience also pointed to the need to advocate reproductive health services for SWs.

Reaction of PWID:

- The audience felt that there is a lot to be done with the procurement and supply of commodities for people who use drugs. They suggested the need to advocate the adoption by county governments of smoother procurement and supply processes for various public health commodities.

Finding and Recommendations on Interventions

This section covered comprehensive health needs in community and prison settings.

Key finding:

- Policies affecting SWs and PWID mention the need for representation by these key populations in programming and the need for integrated and comprehensive health interventions in community settings.

Key recommendations:

- Policy documents need to explicitly address the unique and comprehensive health needs of MSM and TG in community settings.
- Policy documents should state mechanisms to address the unique and comprehensive health needs of key populations in detention and prison settings.

Reaction of MSM and PWID:

- Both of these audiences agreed with the findings and recommendations in this section.

Reactions of SWs:

- The policy on representation is strong but its implementation is not.
- Health issues should be approached from the perspective of human rights: that is, that everyone is entitled to health services.

Additional comments by SWs about the Kenya decision model's findings and recommendations:

- Services in health facilities should be integrated and friendly to SWs and other key populations.
- The entire cycle of programming for key populations should be informed by the inclusive and participatory involvement of all stakeholders, including key populations and law enforcement. This will help law enforcers and other stakeholders understand the needs of key populations and discourage harassment.
- Security issues must be addressed. It was reported that many members of key populations are killed and many of these cases go unreported.

Additional comments by PWID:

The stakeholders appreciated the efforts of the HPP team. They expressed the need for the following cross-cutting concerns to be addressed:

- Policy documents should be categorized as major (laws/regulations/acts of Parliament/national plans) and minor (ministries' strategic plans, guidelines, and operational plans).
- The language of major policies is usually broad and general. Thus, it would be inappropriate to recommend that these documents explicitly mention key populations, PWID, SWs, TG, and MSM. The report's recommendations should stress the need for these major policies to be inclusive.
- The stakeholders shared their experiences and challenges in other forums in convincing decisionmakers to use the term "key populations" in such documents as the midterm plans for Vision 2030. Decisionmakers preferred the term "vulnerable populations" instead.
- The stakeholders mentioned the need for the report to recommend that minor policy documents be aligned with the Constitution of Kenya (especially its clauses on freedom of association and nondiscrimination).
- The stakeholders mentioned that some key policy documents are not within public reach. They recommended that the study team contact organizations working with the prisons for such policy documents as Prisons Health Strategy; NACADA for its policy documents distinguishing amounts of illegal drugs for personal use and for trafficking; and the administrations of Nairobi, Kisumu, and Mombasa for their bylaws.
- The report should list the policy documents reviewed for the decision model analysis.

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