POLICY BRIEF

Barriers in the realization of the right to health services in relation to HIV, TB and SRH

February 2019

ARASA AIDS & Rights Alliance for Southern Africa

LWALA COMMUNITY ALLIANCE

KESWA

KELIN Reclaiming Rights, Rebuilding Lives

About KELIN

KELIN is a human rights NGO working to protect and promote HIV - related human rights in Kenya. We do this by: providing legal services and support, training professionals on human rights, engaging in advocacy campaigns that promote awareness of human rights issues, conducting research and influencing policy that promotes evidence - based change.

About

About the National HIV, TB and Human Rights Training and Advocacy Country Programme (Country Programme)

The Country Programme has been implemented in Kenya since 2017 with the aim of promoting access to HIV, TB, and Sexual Reproductive Health (SRH) services and justice among communities of persons living with and those affected by HIV and TB in Kenya.

The programme has since 2017 been hosted by KELIN in partnership with the Kenya Sex Workers Alliance (KESWA) and LWALA Community Alliance. The AIDS and Rights Alliance for Southern Africa (ARASA) provided financial and technical support for this programme.

The programme has been implemented in five counties namely Kisumu, Migori, Homa Bay, Nairobi and Mombasa.

Introduction

This policy brief provides a summary of some of the social, structural and legal barriers that affect HIV, TB and SRH responses in the community. These barriers were identified in the course of implementation of the National HIV, TB and Human Rights Training and Advocacy Country Programme.

In Kenya, the national adult HIV prevalence rate was estimated at 4.9% in 2017 with prevalence higher among women (5.2%) than men (4.5%). The total number of people living with HIV (PLHIV) was estimated at approximately 1.5 million in 2017, this included 105,200 under 15 years and 1,388,200 aged above 15 years.[1] Further, the HIV prevalence among key populations was estimated at 29.3% for sex workers; 18.2% for men who have sex with men; and 18.3% for injecting drug users.[2]

In relation to tuberculosis (TB), the National TB program estimated that there were 85,188 patients diagnosed with TB in 2017 with children accounting for 9.1% of the patients. Males accounted for 64% of the patients.[3] Kenya is one of the 30 high burden TB countries globally and TB remains one of the leading nine causes of deaths in Kenya.

Over the years, various legal, policy and strategic reforms have been formulated and implemented in response to HIV, TB and SRH challenges in the community. For example, with the promulgation of the 2010 Constitution, Kenyans are now guaranteed the right to the highest attainable standard of health, including reproductive health care. The Constitution further contains a progressive bill of rights section that provides an overall legislative guide for the HIV, TB and SRH response. Other relevant laws include the HIV and AIDS Prevention and Control Act (2006), Health Act (2017), Sexual Offences Act, Children Act, among others.

[1]See National AIDS Control Council (NACC), Kenya HIV Estimates Report 2018
[2]See NACC (2018) Kenya AIDS Response Progress Report 2018
[3]National Tuberculosis, Leprosy and Lung Disease Program (NTLD – P), Annual Report 2017.

Relatedly, government agencies including National AIDS Control Council (NACC), National AIDS and STI Control Programme (NASCOP), National Tuberculosis, Leprosy and Lung Disease Program (NTLD – P), among others, have implemented both national and global strategies in a bid to address issues related to HIV and TB. This has also been supplemented by programmes implemented by non-state actors and development partners.

However, human rights issues arising out of the epidemics remain largely under-addressed thus presenting barriers to access to HIV, TB and SRH services in the community. This policy brief discusses six such human rights-related social, structural and legal issues that act as barriers to access to services. These are identified as follows:

1. Stigma and discrimination in the community against people living with and affected by HIV and TB;
2. Violation of the right to privacy and confidentiality of people living with and affected by HIV and TB;
3. Negative attitudes towards key populations – sex workers, men who have sex with men, injecting drug users, Trans* people – by both the community and health care providers;
4. Lack of access to sexual reproductive health information by the community thus fueling myths and misconceptions that hinder access to services;
5. Increase in sexual and gender based violence cases; and
6. Existence of punitive laws and policies that act as a barrier to access to HIV, TB and SRH services

This policy brief calls upon policy makers to urgently address these issues and recommends some remedial measures.

HIV in Figures

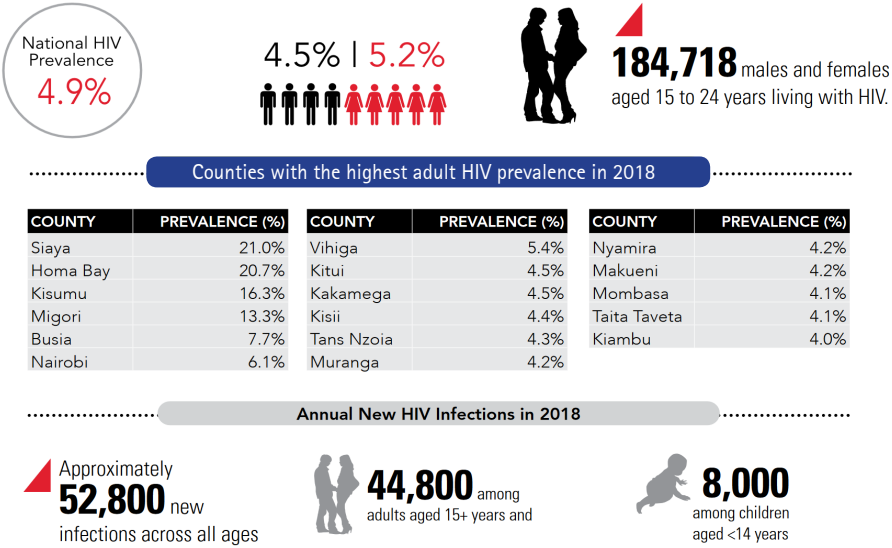
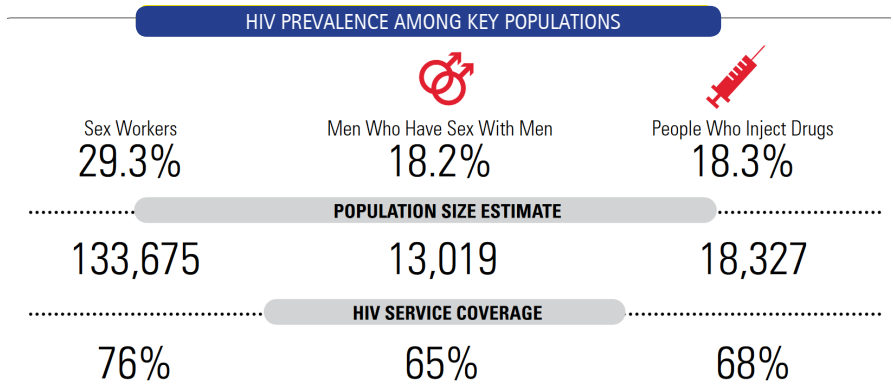


Figure: *Summary of HIV prevalence in Kenya in 2018. The counties where the country programme was implemented include: Homa Bay (20.7%), Kisumu (16.3%), Migori (13.3%), Nairobi (6.1%) and Mombasa (4.1 %) (Source: National AIDS Control Council (NACC) - Kenya HIV Estimates Report 2018)*



Summary of HIV prevalence among key populations in Kenya in 2018 (Source: Kenya AIDS Response Progress Report 2018)

1 Stigma and discrimination in the community against persons living with and affected by HIV and TB;

In 2018, a community health advocate from Mombasa County reported a case where a young woman living with HIV had faced verbal abuses from family members due to her HIV status. The verbal abuses had been persistent and vulgar to the point that neighbors also learned of woman's HIV status. The neighbors in turn shunned the woman and avoided her business. This is not an isolated case.

Persons living with and affected by HIV and TB continue to experience stigma and discrimination from the family, community and institutions where they are supposed to receive services including schools, churches, and hospitals, among others. HIV related stigma refers to prejudice, negative attitudes and abuse directed at people living with HIV. Discrimination in the context of PLHIV involves treating PLHIV in a different, unjust, unfair or prejudicial way, on the basis of their actual or perceived status.[5]

The Kenya AIDS Strategic Framework (2014/2015 – 2018/2019) recognizes that stigma and discrimination is a barrier to HIV prevention and uptake of care and treatment services. And that those who are socially excluded, the poor and vulnerable people who are living with HIV are unlikely to take up services.

Stigma and discrimination persists despite existence of laws prohibiting discrimination based on health status.[5]

[4]Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN) Policy Brief: Six Key Factors in Realizing HIV-Related Human Rights in Kenya: Actions for Policy & Lawmakers. Nairobi, 2015.

[5]See Article 27 Constitution of Kenya and the HIV and AIDS Prevention and Control Act.

Recommendations

UNAIDS6 has recommended that "programmes aimed at reducing stigma and discrimination against people living with HIV or people at risk of HIV infection should address the actionable causes of stigma and discrimination and empower people living with and vulnerable to HIV." And that the "actionable causes are: (a) ignorance about the harm of stigma, (b) continuing irrational fears of infection, and (c) moral judgement."[6]

Therefore, policy makers in Kenya need to:

1. **Put in place policy measures for continuous education and sensitization to empower the community with information about HIV, and the devastating impact of stigma and discrimination;**

2. **Put in place policy measures for continuous education and sensitization of health care workers to reduce stigmatizing attitudes and discriminatory practices at health facility level;**

3. **Implement educational and sensitization programmes for community leaders – including religious leaders, chiefs, teachers, youth leaders, women leaders and other professionals;**

4. **Support community groups and forums, for interaction and sensitization against HIV-related stigma and discrimination;**

5. **Improve the mechanism for access to justice for persons who have faced HIV-related stigma and discrimination in the community**

[6]Joint United Nations Programme on HIV & AIDS (UNAIDS), Guidance Note: Key Programmes to reduce Stigma and Discrimination and increase access to Justice in National HIV Responses. Geneva, 2012

Violation of the right to privacy and confidentiality of persons living with and affected by HIV and TB;

A woman house help aged 48 years in Mombasa County was forcefully taken to a health facility by her employer for HIV testing. This was in blatant violation of her right to privacy. This and similar practices are common.

Persons living with and affected by HIV and TB continue to have their right to privacy and confidentiality breached in a number of ways, including, disclosure of HIV status without consent, and testing without consent.

Health care facilities, medical insurance companies, schools, employers and religious institutions have been accused of being the main culprits in unlawful disclosure of HIV status and forced or coerced HIV testing. For example, in 2018 a religious institution demanded that a couple undergoes HIV testing and presents the results to the institution as a pre-condition for celebration of marriage in that institution.

Some government initiatives have also had the effect of aggravating violation of this right. For example, in 2015, the President of Kenya issued a directive for the collection of names of people living with HIV, including school going children, among others. The directive whose implementation would have breached the right to privacy of PLHIV was later declared unconstitutional.[7]

[7]See Judgment in Petition 250 of 2015 KELIN & 3 others v. Cabinet Secretary Ministry of Health & 4 others available at http://www.kelinkenya.org/wp-content/uploads/2018/04/Petition-250-Judgement.pdf (accessed Jan 3, 2019).

Violation of the right to privacy and confidentiality contributes to high levels of stigma and discrimination, violence against those who are vulnerable and consequential loss of other rights. Violations of this right continue despite constitutional protection of the right to privacy (Article 31); and prohibitions against HIV testing and disclosure without consent by the HIV and AIDS Prevention and Control Act, 2006 (HAPCA).

Recommendations

In order to reduce violation of the right to privacy and confidentiality, it is recommended that policy makers:

1. **Ensure the training of health care workers on the rights of PLHIV, with particular regard to the right to privacy and confidentiality of medical condition and information and the legal and policy framework in place.**

2. **Put in place policy measures for continuous education and sensitization of teachers, employers, religious leaders, law enforcement officers, on the importance of respecting and protecting privacy and confidentiality of people living with and affected by HIV;**

3. **Put in place policy measures for systematic monitoring of the implementation of laws and policies aimed at protecting the right to privacy and confidentiality of PLHIV;**

4. **Ensure that there are regular formal engagements within communities through informal gate keepers and opinion leaders regarding rights of PLHIV to educate the community and reduce breach of rights to privacy and confidentiality.**

3

Negative attitudes towards key populations

Sex workers, men who have sex with men (MSM), injecting drug users, Trans* people, experience negative attitude by both the community and health care providers thus hindering access to health service.

Community Health Advocates reported incidents where both the community, health care workers and law enforcement officers displayed negative attitudes towards key populations. In Migori County for example, there was a reported case of physical assault of two individual known members of an MSM group. In Mombasa County, a Trans* woman faced verbal abuses at a health facility.

It should be noted that key populations who include sex workers, men who have sex with men (MSM) and drug users experience double stigma associated with HIV status, and moral judgment by the community on their sexual behavior.

Key populations have also reported facing stigma and discrimination at health facilities, in addition to violation of their right to privacy and confidentiality. They have also faced violence, harassment, stigma and discrimination from the community and law enforcement officers. This is exacerbated by laws criminalizing sex work, drug use and homosexuality – which have the effect of driving key populations underground and discourage them from seeking health services.

Recommendations

It is recommended that policy makers need to:

1. **Embrace a human rights approach to facilitate access to health services for sex workers, men who have sex with men, drug users and other marginalized and vulnerable groups in the society;**

2. **Embrace and put in place policy measures to support programmes for key populations to access health services including provision of key commodities including lubricants and condoms, needle and syringe programme (NSP), Medically Assisted Therapy for opioid dependents (MAT), among others;**

3. **Address the issue of violence against key populations, and the constant harassment by law enforcement officers.**

4. **Implement continuous education and sensitization for health care workers to address stigma, discrimination and breach of privacy at health facility level;**

5. **Adapt legal frameworks to decriminalize sex work, drug use and homosexuality.**

1

Lack of access to sexual reproductive health information by the community thus fueling myths and misconceptions that hinder access to services

Community health advocates reported that communities lack access to relevant sexual reproductive health information to enable them claim their rights.

Health facilities and other government health departments have been accused of not facilitating access to the much needed information especially on family planning, maternal health, redress for sexual violence, sexual and reproductive health of sexual minorities, adolescents, persons with disability, PLHIV, among others.

Adolescent and young people, especially women, are particularly negatively impacted by the lack of access to SRH information.

Access to information and the right to sexual and reproductive health are fundamental human rights, which the government must strive to fulfil.

Recommendations

Policy makers should:

1. Implement education policy, guidelines and teacher training that includes age appropriate HIV, sexual and reproductive health and rights;

2. Improve access to accurate information on sexuality through introduction of age appropriate comprehensive sexuality education in school curriculum;

3. Support community health volunteers to disseminate information including on basic SRH knowledge e.g. on contraceptives;

4. Ensure that appropriate, adequate and comprehensive information is disseminated on health including:

    - **The types, availability and cost of health services in the community;**
    - **How health services are organized;**
    - **The operating schedules and timetables of facilities;**
    - **Procedures for access to the health services;**
    - **Procedures for laying complaints;**
    - **The rights and duties of users and health care providers;**

Increase in sexual and gender based violence cases

Sexual and gender-based violence (SGBV) refers to any harmful act that is perpetrated against one person's will and that is based on socially ascribed (gender) differences between males and females. It includes acts that inflict physical, mental, or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty, whether occurring in public or in private life. [8]

Community health advocates (CHAs) reported an increase in sexual and gender based violence cases including defilements, rape, marital violence, sexual violence against sex workers, men who have sex with men, among other marginalized and vulnerable groups.

Further, CHAs reported that most SGBV survivors still experience challenges in accessing justice. Most cases are not reported to the relevant authorities due to intimidation by perpetrators, pressure for out of court settlement, ignorance of the justice system, corrupt practices in the corridors of justice, and a general dismissive and contemptuous attitude towards such cases by law enforcement officers.
In addition, financial constraints have been reported to hinder access to justice for survivors of SGBV. For instance, some health facilities charge to conduct medical examination on SBGV survivors and the eventual filling of P3 forms.

[8]See UN Declaration on the Elimination of Violence against Women (1993).

The National Gender and Equality Commission (NGEC)[9] identify the following as among other persisting challenges in relation to SGBV:

- Persistence biased socio-cultural attitudes, beliefs and behaviours in society that perpetuate negative stereotypes, and discrimination and gender inequality.
- Trivialisation of SGBV experienced by men and boys.
- Ineffective enforcement of legislation.
- Legal illiteracy and general lack of awareness on SGBV.
- Absence of or limited shelters/safe houses.
- Poor monitoring and evaluation mechanisms.
- Lack of DNA laboratories at the county level resulting into weak chain of custody of forensic evidence resulting in acquittals.

Recommendations

1. Remove financial barriers to medical examination for survivors of sexual and gender based violence and specifically fees charged at health facility for medical examination and filing of P3 forms (which is critical to access justice);
2. Put in place measures for continuous public education on SGBV in the community;
3. Ensure continuous capacity building of those coming into contact with survivors of SGBV (and those at high risk of SGBV) including health care providers, law enforcement officers, and community leaders, among others.
4. Facilitate free legal assistance, advice, advocacy and other support services to survivors, and accessible information about their rights and entitlements.
5. Ensure implementation of laws and policies in place to prevent and as redress mechanism for SGBV.
6. Promote gender equality and SGBV prevention programmes in the community, educational institutions, among others.

[9] See National Gender and Equality Commission (NGEC) County Government Policy on Sexual and Gender Based Violence. Nairobi, 2017

Existence of punitive laws, policies, and practices that act as barriers to HIV, TB and SRH services

There are laws, policies and practices that act as barriers to the effective prevention, management, control and treatment of HIV and TB.

First, laws that criminalize people for having HIV violate human rights and undermine public health efforts to control the epidemic. There is no evidence that applying the criminal law to HIV reduces its spread. Rather, such approaches promote fear and stigma about HIV, can adversely affect relationships between patients and health-care providers, and can discourage people from seeking HIV testing and treatment. Further, because women are often the first in a household to learn their HIV status, they can become vulnerable to blame and violence.[10] Section 26 of the Sexual Offences Act, 2006 has this impact and has been used to prosecute people living with HIV on allegations of HIV non-disclosure, exposure and transmission,

Second, sex work, drug use and consensual same sex relations among adults are criminalized. This

[10] See UNAIDS Policy Brief: Criminalization of HIV Transmission. Geneva, 2008.

criminalization has the unintended and negative consequences for public health, discouraging sex workers, MSMs and drug users from seeking HIV-related prevention, treatment, care and support for fear of prosecution. The implementation of prevention programmes, for example needles and syringe programme, is significantly hindered.

New research concludes that decriminalization of adult consensual sex work could significantly reduce HIV infection among sex workers. A review of 27 countries found that "countries that have legalized some aspects of sex work have significantly lower HIV prevalence among sex workers," especially if such legalization operates in concert with fair and effective law enforcement.[11]

Third, community health advocates have raised concerns on implementation of policies on self-testing, test and treat and proposals around partner notification guidelines. There are concerns that there is lack of supportive pre and post-test counseling under the Test and Treat approach and self-testing. Further, there are concerns on the likelihood of partner notification guidelines violating right to privacy and confidentiality hence exposing PLHIV to stigma, discrimination and other human rights violations.

Fourth, community health advocates from Mombasa reported a case from a leading health institution where mothers had been detained at the facility (post-delivery) because of inability to pay maternity fees. Similar cases have been reported in Nairobi, and Kisumu. This shows that the practice of detaining mothers at facilities (both public and private) for inability to pay for maternity services is prevalent. This is despite the practice being illegal – as guided by section 5 of the Health Act and court decisions. [12]

[11] Reeves, A., et al., (2017), National Sex Work Policy and HIV Prevalence Among Sex Workers: An Ecological Regression Analysis of 27 European Countries, The Lancet HIV, 4:3 134 - 140. Available at: https://www.thelancet.com/pdfs/journals/lanhiv/PIIS2352-3018(16)30217-X.pdf

[12] See M A O & another v Attorney General & 4 others [2015] eKLR.

Recommendations

1. Decriminalize HIV exposure, non-disclosure and un-intentional transmission through review of section 26 of the Sexual Offences Act;

2. Decriminalize consensual same-sex relations among adults through review of Section 162 of the Penal Code;

3. Put in place measures to ensure implementation of policies for example test and treat, self-testing and partner notification guidelines do not violate rights of PLHIV;

5. Review drug use laws especially Section 5 of the Narcotic Drugs and Psychotropic Substances (Control) Act

6. Put in place policy measures to ensure that mothers are not illegal detained at health facilities post-delivery (for inability to pay (any) maternal fees).