Using Legal Aid to Facilitate Access to Justice for People Living with HIV in Kenya[1]- The Experience of KELIN

Abstract

Despite progress in the response to the HIV epidemic in Kenya, pervasive stigma, discrimination, gender inequality, negative norms and practices, and human rights violations associated with HIV remain serious challenges hindering access to HIV services. [2] Access to justice for those affected by HIV is therefore a distinct need that must be included in efforts to facilitate legal aid in Kenya. This paper analyzes the experience of KELIN[3] in providing legal aid to facilitate access to justice for people living with HIV (PLHIV) in Kenya in different contexts.

The paper discusses two legal aid strategies that KELIN has used to facilitate access to justice for vulnerable HIV affected persons. These include strategic litigation and pro bono provision of legal advice to HIV affected persons. On Strategic litigation, the paper discusses several strategic cases litigated by KELIN and their impact. The paper further expounds on how KELIN sought, with the use of strategic litigation, to establish policy positions on key issues with a view to holding duty bearers, and government in particular, accountable in regard to the protection and facilitation of human rights of PLHIV in different contexts. The cases discussed address human rights violations in the workplace, in healthcare facilities and institutions of learning among others.

Some of these cases include: *J.A.O. v Homepark Caterers Ltd & 2 others [2004] eKLR* relating to testing for HIV without consent and termination of employment based on HIV status; *P.A.O & 2 Others V Attorney General [2012] eKLR* which focused on intellectual property rights hindering access to medicines for people living with HIV; *KELIN & 3 others v. Cabinet Secretary Ministry of Health & 4 others [2016]* that challenged an unconstitutional presidential directive that violated the right to privacy of children living with HIV; the cases of *SWK & 5 others, and LAW & 2 others* that are challenging the forced and coerced sterilization of women living with HIV. The paper also discusses the case of *Daniel Ng'etich & 2 others v Attorney General & 3 others [2016] eKLR,* that challenged the practice of detention of people with TB in prison facilities.

On the second aspect, the paper addresses the provision of legal aid through legal advice and information through research for cases affecting HIV affected people in courts and tribunals. In this instance, the paper highlights how KELIN has over the years, developed a partnership with pro bono- lawyers who are supported with training on Health and HIV related human rights and in turn provide counsel and represent walk-in clients, clients referred by other organizations, and clients who attended legal aid clinics set up in regions with high burden of HIV infection. The paper analyzes the two-pronged strategy adopted by KELIN to realize results in this aspect.

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[2] See Michael Eba P. (2016). The HIV and AIDS Tribunal of Kenya: An Effective Mechanism for the Enforcement of HIV-related Human Rights? *Health and human rights*, *18*(1), 169–180*;* KELIN (2018) *Trends in HIV & TB Human Rights Violations and Interventions.*

[3] The Kenya Legal and Ethical Issues Network on HIV/AIDS (KELIN) is a Kenyan human rights organization that advocates for a holistic and right-based system of service delivery in health and for the full enjoyment of the right to health. More information about KELIN can be accessed at www.kelinkenya.org

Part 1: Introduction

The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that, globally, 38 million people are living with HIV out of which 25.4 million people now on treatment.[4] The estimates further indicate that new HIV infections have been reduced by 23% since 2010, thanks in large part to a substantial decrease of 38% in eastern and southern Africa. But HIV infections have increased by 72% in eastern Europe and central Asia, by 22% in the Middle East and North Africa and by 21% in Latin America. Globally, there were still 690 000 AIDS-related deaths in 2019 and 1.7 million new infections. In sub-Saharan Africa, young women and adolescent girls accounted for one in four new infections in 2019, despite making up about 10% of the total population.[5]

HIV continues to be a major global public health issue. Since the start of the epidemic, an estimated 74.9 million people have become infected with HIV and 32 million people have died of AIDS-related illnesses. The vast majority of people living with HIV are located in low- and middle-income countries, with an estimated 68% living in sub-Saharan Africa.[6] The gaps in HIV responses and resulting HIV infections and AIDS-related deaths lie upon fault lines of inequality. Data from 46 countries in sub-Saharan Africa show a positive relationship between HIV prevalence and income disparity. Younger women are at particular risk. In sub-Saharan Africa, adolescent girls and young women (aged 15 to 24 years) accounted for 24% of HIV infections in 2019, more than double their 10% share of the population. Women and girls of all ages accounted for 59% of new HIV infections in sub-Saharan Africa. Unequal gender norms that limit the agency and voice of women and girls, reduce their access to education and economic resources, and stifle their civic participation contribute to the higher HIV risk faced by women in settings with high HIV prevalence. Women living with HIV face particular challenges, as HIV stigma and gender inequality intersect and negatively impact their health. While health-care settings should be safe spaces, as many as one in three women living with HIV across 19 countries report experiencing at least one form of discrimination related to their sexual and reproductive health in a health-care setting within the past 12 months.[7]

It is estimated that the total number of people living with HIV (PLHIV) in Kenya in 2017 was 1.5 million.[8] This includes 105,200 children under 15 years and 1,388,200 people aged 15 years and above. Further, the estimates indicate that of the total number of people living with HIV, 184,700 (12%) were among youth 15-24 years of age.

Since the first case was detected in Kenya in 1984, HIV has been one of the major causes of illness in the country, putting huge demands on the healthcare system as well as the economy. For instance, in 1996, 10.5% of Kenyans were living with HIV although the prevalence has steadily declined over the years. In 2017, 4.9% people were living with HIV with prevalence higher among women (5.2%) than men (4.5%).

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[4] UNAIDS (2020) *Seizing the Moment: Tackling entrenched inequalities to end epidemics* Geneva, Switzerland.
[5] ***Ibid.***
[6] Avert (2020) "Global HIV and AIDS Statistics," available at https://www.avert.org/global-hiv-and-aids-statistics <accessed 1 Dec 2020).
[7] UNAIDS (2020) *Seizing the Moment: Tackling entrenched inequalities to end epidemics* Geneva, Switzerland.
[8] Ministry of Health (MoH) (2018) *Kenya HIV Estimates Report 2018*, Nairobi.

Kenya has both a generalized and concentrated epidemic, with higher levels of HIV among certain key affected populations. These include youth between ages 15 and 24, people who inject drugs (PWID, 18.3%), men who have sex with men (MSM, 18.2%), and sex workers (29.3%).

In the initial stages when HIV was first diagnosed in Kenya, the government chose to deal with the pandemic as a medical problem. Strategic plans at the time focussed on creation of awareness about AIDS, blood safety, clinical management of AIDS opportunistic infections and capacity building for management of AIDS control at the national level. The period of 1988 -1991 saw the government appraise the HIV and AIDS situation and acknowledge it as a key public health problem. however, the response was still driven by the Ministry of Health, which relied heavily on general public education to address the epidemic. This strategy of dealing with HIV as a purely medical problem heightened stigma and discrimination of people living with HIV (PLHIV).

In the 1980's and 1990's, stigmatization against people suspected to have any link with HIV & AIDS was high. Anyone who died on suspicion of having HIV-related complications was put in a polythene bag and buried within a day. The bereaved were not allowed to view the bodies of their deceased relatives, as is the custom. There were also instances where the bodies were buried by force. Further, the extent of stigma was so high that people did not want to be seen to be participating or attending any public forum discussing HIV & AIDS. These sorts of meetings were regarded with suspicion by many, including local authorities. Parliamentary discussions in the years preceding the formation of a taskforce and an AIDS policy (1992 – 1997) reveal that there was a lot of ignorance. Since then, there has been a shift in attitudes.

The period of 1992-1995 noted significant changes in the HIV and AIDS policy as the first surveillance data was released in 1992. The government also commissioned a Socio- Economic Impact Assessment (SEIA). The second medium term plan that spanned the period 1992-1996 was developed. Apart from focusing on the previous strategies, this plan sought to additionally focus on the strengthening of multi-sectoral collaboration in responses to HIV and AIDS. The plan also emphasised the need to provide care and social support to people infected with HIV, their families and community. The need to reduce the socio-economic impact of HIV & AIDS and the strengthening of national and district capacity to respond to the epidemic was addressed in the plan. Between the periods of 1995 – 1997 the government put in place a national structure of consultation to identify relevant policies to drive the response to HIV, this finally culminated in the development of Sessional Paper No. 4 of 1997. The Sessional paper was developed to provide a policy framework within which AIDS prevention and control would be undertaken. The paper sought to give directions on how to handle controversial issues relating to HIV while taking into account prevailing circumstances and the social-cultural environment. The paper sought to enable government to play a leadership role in AIDS prevention and control activities by promoting a multi-sectoral approach.

1.1.Formation of KELIN

UN bodies like UNDP were also concerned about its ravages to the economies of developing countries. HIV was not only a health issue but also an economic one. It had economic overtones as it affected production and created multi-sectoral issues. This realization that HIV created multi-sectoral issues led to the 1st Intra-African meeting in Ghana in October 1992. The meeting was organized by UNDP. The aim of the meeting was to bring all African countries together to address HIV from a human rights and economic point of view. Those who attended the meeting were

Kivutha Kibwana (human rights lawyer), Dorothy Odhiambo (University of Nairobi), Joe Muriuki and Jane Ngima, and Ambrose Rachier (lawyer).

It was resolved that each participating African country forms a legal and ethical network to address legal and ethical issues surrounding HIV & AIDS. They took acronyms of their countries. The founders of KELIN were driven by the need to understand the HIV & AIDS epidemic. This was at a time when knowledge about HIV and AIDS was not widespread and there were many misconceptions that perpetuated stigma. KELIN set out to create awareness, especially on legal rights and how to handle HIV/AIDS matters from a human rights perspective. The most pertinent question was one of confidentiality. It was believed and argued that the public was at a greater risk if the statuses of people living with HIV (PLHIV) were not made public, leaving PLHIV with hardly any rights.

The tension was therefore between the rights of PLHIV as far as confidentiality was concerned vis-à-vis keeping the public safe. However, revealing the status of PLHIV (exposing them to stigma) only exacerbated the problem leading to higher rates of infection. The first task of the KELIN team was therefore to create an environment that would mitigate the spread of HIV. KELIN therefore began its operations in April 1993 under the auspices of UNDP. This was the birth of KELIN's legal aid programme to communities in matters concerning HIV and human rights.

The need for legal aid for PLHIV has existed since 1984, when the first case of HIV was diagnosed in the country. People living with HIV and key affected populations in Kenya continue to experience discrimination in their families and communities, and in structures and institutions where they seek services. A 2013 study reported that women living with HIV experience higher levels of stigma than men (4.9% versus 2.7%). Employment-related discrimination against PLHIV has also been widely documented. People experiencing stigma are more than four times more likely to report poor access to care. Stigma and discrimination remain pervasive in Kenya, both in relation to positive HIV status and to belonging to a key population, with a negative impact on access to and uptake of HIV-related services. This includes stigma and discrimination across a range of settings including schools, workplaces, health facilities and communities. It is particularly pronounced in more rural areas. Members of key and vulnerable populations face layered stigma and discrimination, the manifestations of which vary by population but which can constitute major barriers to services. Sexual and gender violence increases biological vulnerability to HIV, reduces ability to negotiate for safer sex, with long-term psychosocial outcomes that impact sexual risk taking behaviour. Gender inequalities and cultural practices including wife inheritance, sexual and gender based violence, early marriages and high attrition in school limit effective HIV prevention.[9]

In response to the legal and ethical issues, laws and policies in the HIV response have evolved from the inclusion of a chapter on legal issues in Sessional Paper No. 4 of 1997, to the establishment of a task force on legal issues relating to HIV & AIDS in June 2001. The Taskforce[10] documented and recommended that the following issues be addressed: the question of testing: privacy and confidentiality; HIV & AIDS in the workplace; HIV & AIDS in prisons and other places of confinement; HIV & AIDS and the criminal Law; HIV & AIDS and issues of succession and inheritance; HIV & AIDS and insurance; HIV & AIDS and biomedical research; HIV & AIDS

[9] NACC (2014) *Kenya AIDS Strategic Framework 2014/2015 - 2018/2019*

[10] Gazette notice No. 4015 of 22nd June 2001.

and the rights of the child; HIV & AIDS and gender issues; HIV & AIDS and the law of patents; HIV & AIDS and cultural and religious matters; and the rights and responsibilities of PLHIV and other related matters. The launch of the report of the task force in July 2002 consequently led to the drafting of the HIV & AIDS Prevention and Control Bill, 2002. The bill was passed into law in December, 2006 and became operational in February, 2009.

KELIN founding members engaged in the formulation of the Sessional Paper, in the Taskforce on legal issues relating to HIV as well as in the drafting of the HIV & AIDS Prevention and Control Act, 2006 (HAPCA).

The legal aid programme by KELIN was further augmented by the promulgation of the Constitution on 27 August, 2010 which provided a new milestone in the field of HIV.

The next sections of this paper discuss KELIN's legal aid model in facilitating access to justice for PLHIV in Kenya. As highlighted, the Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN) was formed in 1994 and registered as a Non-Governmental Organization (NGO) in 2001. It was established following a workshop in Accra, Ghana which focused on creating country-based networks that intersect law, ethics, human rights, and HIV. While originally created to protect and promote HIV-related human rights, the scope of KELIN's work has expanded to also include sexual and reproductive health and rights, key and affected populations, HIV and TB, litigation, women land and property rights and health governance.

Part 2: Using legal aid to facilitate access to Justice for PLHIV in Kenya:

In this section, we discuss KELIN's three-tier legal aid model of training communities of people living with HIV, training of lawyers, and partnering with the trained pro bono lawyers to facilitate access to justice.

The Legal Aid Act, 2016 defines legal aid to include legal advice; legal representation; assistance in resolving disputes by alternative dispute resolution; drafting of relevant documents and effecting service incidental to any legal proceedings; and reaching or giving effect to any out-of-court settlement; creating awareness through the provision of legal information and law-related education; and recommending law reform and undertaking advocacy work on behalf of the community.[11]

Generally, legal aid is a powerful tool in ensuring access to justice especially for the vulnerable and marginalized in the community. This has been underscored by UN Member States as follows: "we emphasize the right of equal access to justice for all, including members of vulnerable groups, and the importance of awareness-raising concerning legal rights, and in this regard we commit to taking all necessary steps to provide fair, transparent, effective, non-discriminatory and accountable services that promote access to justice for all, including legal aid." [12]

In the HIV response, legal aid is important for at least three reasons. First, legal aid and provision of HIV-related legal services is recognized as an essential component of an effective national HIV

[11] Section 2, Legal Aid Act, 2016.

[12] United Nations (2012) *Declaration of the High-level Meeting of the General Assembly on the Rule of Law at the National and International Levels* UN Resolution *A/RES/67/1*

response.[13] Through provision of legal services, human rights of PLHIV are protected and promoted. Second, legal services contribute to creating an enabling environment where people access HIV prevention, treatment, care and support services, people claim and enforce their rights to access HIV services, and problems that create vulnerability to HIV are addressed.

The Global Commission on HIV and the Law also makes a case for legal aid in the HIV response noting that "effective legal aid can make justice and equality a reality for people living with HIV, and this can contribute to better health outcomes. Advocates can creatively use traditional law in progressive ways to promote women's rights and health. Court actions and legislative initiatives, informed by fairness and pragmatism, can help nations shrug off the yoke of misconceived criminalisation, introduce gender-sensitive sexual assault law and recognise the sexual autonomy of young people." [14]

The need for legal aid and the need to promote and protect human rights in the HIV response is important in at least three ways. First, lack of human rights protection creates vulnerability to HIV, particularly among marginalized and underserved groups such as women, children, and young persons; sex workers; people who use drugs; migrants; men who have sex with men (MSM); transgendered persons; and prisoners. Second, lack of human rights protection fuels stigma, discrimination, and violence against persons living with and affected by HIV. These harmful attitudes and practices are rooted in a lack of understanding of HIV, misconceptions about how HIV is transmitted, and "fears and prejudices surrounding sex, blood, disease, and death—as well as the perception that HIV is related to 'deviant' or 'immoral' behaviors such as sex outside marriage, sex between men, and drug use." Third, lack of human rights protection impedes effective national responses to HIV. Discriminatory, coercive, and punitive approaches to HIV increase vulnerability to infection and worsen the impact of the epidemic on individuals, families, communities and countries.[15]

"Human rights are inextricably linked with the spread and impact of HIV on individuals and communities around the world. A lack of respect for human rights fuels the spread and exacerbates the impact of the disease. This link is apparent in the disproportionate incidence and spread of the disease among key populations at higher risk, and particularly those living in poverty. It is also apparent in the fact that the overwhelming burden of the epidemic today is borne by low- and middle-income countries. AIDS and poverty are now mutually reinforcing negative forces in many of these countries."[16]

It is against this background that KELIN designed a three-tier legal aid model to facilitate access to justice for PLHIV. This model stems from the fact that a legal framework exists to protect HIV-related rights in Kenya.

First, the Constitution of Kenya has an expansive Bill of rights with provisions that can be used to support and safeguard the rights of PLHIV to equally access services. Article 19 (1) provides that

[13] International Development Law Organization (IDLO) and United Nations Joint Programme on HIV/AIDS (UNAIDS) (2009) *Toolkit: Scaling Up HIV-Related Legal Services*

[14] Global Commission on HIV and the Law (2012) *Risks, Rights & Health* UNDP, HIV/AIDS Group, New York, NY.

[15] Angela Duger, Sarah Dougherty, Till Baeringhausen, Ralf Jurgens "HIV, AIDS, and Human Rights," available at https://www.hhrguide.org/2014/03/05/471/ <accessed 29.11.2020>

[16] OHCHR "HIV/AIDS and Human Rights," available at https://www.ohchr.org/en/issues/hiv/pages/hivindex.aspx <accessed 29.11.2020>

the Bill of Rights is an integral part of Kenya's democratic state and is the framework for social, economic and cultural policies. The rights and fundamental freedoms in the Bill of Rights further belong to each individual and are not granted by the State [Article (19(3)(a)]. These rights include: the "right to the highest attainable standard of health" which includes the "right to health care services, including reproductive health care."; the right to life; the right to inherent dignity and to have that dignity respected; the right to freedom and security; the right to privacy including the right not to have information relating to their family or private affairs unnecessarily required or revealed; freedom of movement; the right to own property including the equal right to inherit property; the right to fair labour practices; the right to education, social security, housing, water and food; the right to marry and found a family; the right to the protection of the health and safety of all consumers; the right to fair administrative actions and access to justice, among others.

Article 48 of the Constitution of Kenya (2010) provides that the state has an obligation to ensure access to justice for all persons and if any fee is required, it is reasonable and does not impede access to justice. The right to access justice is an immediate right and not progressive, therefore the government should ensure that all citizens access justice always.[17]

Second, the HIV and AIDS Prevention and Control Act, 2006 (HAPCA) which is crucial to ensure the rights of PLHIV and those affected by HIV are protected. For instance, the Act makes provisions that prohibit compulsory testing and makes it an offence to compel another person to undergo an HIV test. The Act also prohibits compulsion to undergo an HIV test as a precondition (or for the continued enjoyment of) employment; marriage; admission to school; entry or travel out of the country; provision of health care, insurance cover or any other services.[18] The Act also makes provision for informed consent prior to HIV testing[19]; provisions for pre-test and post-test counseling where every testing centre is required to provide pre-test and post-test counselling to a person undergoing an HIV test and any other person likely to be affected by the results of such test;[20] provisions for protection of HIV test results[21]; provisions for privacy and confidentiality[22]; provisions prohibiting discriminatory practices at the workplace, school, insurance, travel, burial, health institutions, among others.[23] The Act further establishes the HIV and AIDS Tribunal with jurisdiction (excluding criminal) to hear and determine complaints arising out of any breach of the Act.

Despite this relatively progressive legal framework and justice system, PLHIV and key affected populations in Kenya often do not know their rights or how to claim them. Moreover, the majority of Kenyans lack access to both formal and informal justice systems. Punitive laws still hinder access to HIV services and promote harmful behaviours, especially among key affected populations.

[17] KELIN (2015) "Six Key Factors in Realizing HIV-Related Human Rights in Kenya: Actions for Policy & Lawmakers," available at http://www.kelinkenya.org/wp-content/uploads/2015/11/HIV-TB-POLICY-BRIEF_Commonwealth-Foundation_2015.pdf <accessed 1 Dec 2020>.
[18] See section 13 of the Act
[19] See section 14 of the Act
[20] Section 17
[21] Section 18 of the Act
[22] Sections 20 – 23 of the Act
[23] Sections 31 -38

KELIN's three-tier legal aid model is as discussed below:

2.1.1. Training of communities and PLHIV

> *"Empowering people and communities to know their rights, building legal literacy, and providing quality legal services are essential components of an enabling legal environment. They must be part of the essential services package, along with HIV awareness, testing, treatment, and support services."*[24]

To make rights real, people need to understand their rights, recognize when they have been violated, and have the confidence and support to seek legal redress.[25] The first part of KELIN's model focuses on empowering the community or people living with and affected by HIV about their rights. This is in recognition of the fact that with good legal information, key affected populations and general community members can become aware of and act on behalf of their rights. As such, KELIN has over time conducted community trainings in HIV high burden counties for instance Kilifi, Mombasa, Kwale, Nairobi, Kisumu, Homabay, Migori, Bungoma, Kakamega, among others.

During the trainings, affected communities are empowered to recognize, document, report and initiate legal proceedings in response to human rights violations. During the trainings, KELIN (i) shares with communities information and knowledge on basic human rights concepts and the link between human rights and HIV; (ii) assists the communities understand the various challenges raised by the legal and ethical issues in HIV; (iii) promotes comprehensive rights based knowledge on HIV related rights to influence positive action within the key affected population; (iv) assists the community understand the legal provisions protecting the rights of PLHIV and the available redress mechanisms; (v) shares with the community the roles and responsibilities of the key players in the fulfillment of HIV related human rights; (iv) enhances practical skills in identification and follow up of violations of HIV related human rights; among other objectives.

2.1.2. Training lawyers on HIV and human rights

The second part of KELIN's legal aid model involves creating a pool of legal practitioners equipped to offer HIV related legal services and advocate for legal reforms. Training forums, which clarify the role of legal professionals in promoting HIV related human rights, help lawyers better understand the link between HIV and human rights. The trainings target legal practitioners with interest or experience working with PLHIV in order to increase the pool of legal practitioners available to offer HIV related legal services. The trainings cover human rights, legal awareness on HIV and TB, legal advice and representation of HIV related matters. The trained lawyers would then commit to join KELIN's team of pro bono lawyers offering specialized HIV related legal services and participating in legal aid clinics to provide legal counsel to persons living with and affected by HIV. KELIN currently has a data base of over 100 lawyers who have been trained and available to provide legal support to those who need it.

[24] IDLO (2017) *Equal Rights, Equal Treatment, Ending Aids: Strengthening and expanding HIV-related legal Services and rights*
[25] IDLO (2017), *ibid.*

The pro bono lawyers are called in where programmes at KELIN encounter violations that require legal intervention. These violations may not directly fall under KELIN's mandate, However, pro bono lawyers assist victims in seeking justice where needed. KELIN also partners with pro bono lawyers to support the cases assigned, where the office may not have the capacity to offer representation. Pro bono lawyers also offer support to partners, particularly those based outside Kenya, who want to be enjoined in various cases. For example, the formers special rapporteur for the right to health Annad Grover, was represented by some of the KELIN trained probono lawyers in a case seeking to protect the right to privacy and confidentiality of children who are living with HIV and their guardians.

2.1.3. Linking PLHIV who face rights violations to the trained lawyers

The third wheel in the legal aid model revolves around linking PLHIV and communities whose rights have been violated to the trained lawyers to pursue justice.

The trained lawyers come in handy to represent PLHIV in both the HIV and AIDS Tribunal, magistrate's courts, and the High Court. The lawyers also provide free legal services during legal aid camps and community awareness forums hosted by KELIN and other partners.

KELIN in-house lawyers attend to clients on a daily basis, especially the 'walk-in' clients, those who call the office numbers or email for legal support. After analysis of the case, KELIN either provides legal advice to the clients or links them to the pro bono lawyers for legal representation. KELIN, with financial support from donors, provides financial support to cover the costs of the litigation.

Some of the cases litigated by the pro bono lawyers include: the case of *C.N.M -vs- The Karen Hospital Limited Case No. HAT 008 of 2015* where the claimant had visited the Respondent hospital to seek treatment for severe diarrhoea. The claimant was however subjected to a HIV test without her informed consent which test indicated that she was HIV positive. The claimant later on learnt that information of her HIV status had been shared with her Insurance Company without her consent. In determining the case, the Tribunal held that the claimant had been compelled to undergo HIV testing without her informed consent contrary to sections 13 and 14 of HAPCA. The claimant was thus awarded Kshs. 1,000,000/- in damages. Further, the Tribunal held that forwarding an invoice or bill to a medical insurer violate section 22 of HAPCA if the HIV status of the patient treated could reasonably be inferred from such invoice or bill. The Tribunal awarded the claimant damages of Kshs. 1,500,000/- for this violation.[26]

In another case, *E.M.A -vs- World Neighbours & Another Case No. HAT 007 of 2015* the claimant had been admitted to hospital due to bacterial meningitis owing to her HIV sero-status. Consequently, after learning of the claimant's HIV status, the 2nd respondent, an insurance company, declined to pay the claimant's medical bill to a tune of Kshs. 49,133/=. However, the bill was settled by the 1st respondent on condition that the claimant would settle the amount in 12 months. Several months later the claimant was again admitted to hospital due to jaundice, where her hospital bill accumulated to Kshs. 138,740/=. The 2nd respondent declined to settle the bill albeit the ailment being within the scope of the insurance cover. The claimant was later laid off for

[26] See *The HIV and AIDS Tribunal Compendium of Cases* available at http://www.kelinkenya.org/wp-content/uploads/2016/11/Compedium_HIV-AIDS-Cases_29-Nov-.pdf <accessed 2.12.2020>

reasons that the 1st respondent was undergoing restructuring rendering her position redundant. She claimed compensation from the Respondents on the basis that: her employment was terminated as a result of discrimination based on her HIV status; the 2nd Respondent refused to pay her medical bills based on discrimination as any person could suffer from the illnesses on which account she was hospitalized; she sustained emotional distress and trauma when she was detained in the hospital for lack of funds to offset the bill as well as when her employment was terminated while she was heavily pregnant and could not provide for her children as she used to. In determining the case, the Tribunal noted that it was illegal for an Insurance Company to create a separate cover for PLHIV requiring the persons to disclose their HIV status, prior to obtaining a cover. And that it was also illegal to have two types of medical covers, one for HIV positive persons, and another one for HIV negative persons.[27]

KELIN developed a Compendium of Cases of the HIV and AIDS Tribunal to support lawyers, judges, legal researchers, students, and the general public in understanding and appreciating how the law has been applied and interpreted to protect and promote the rights of PLHIV. The Compendium also aimed at igniting legal discourse on HIV and AIDS laws and policies in Kenya.[28] Earlier, KELIN, working with UNDP, had developed a *Compendium of Judgments, HIV, Human Rights and the Law* to support the Judicial Dialogue on HIV, Human Rights and the Law in Eastern and Southern Africa, jointly convened by UNDP, UNAIDS, Judicial Training Institute, Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN) on 28–31 October 2013 in Nairobi, Kenya.[29]

3. Use of strategic litigation to advance health and HIV related rights for vulnerable groups affected by HIV

3.1. Why Strategic litigation to advance HIV-related human rights

Strategic litigation is litigation with an intended impact beyond a particular case to influence broader change at the level of law, policy, practice, or social discourse.[30] In strategic litigation (also referred to as "test cases," "impact litigation" or "public interest litigation"), the court system is used to achieve legal and social change that benefits more people than the individual involved in the specific court case.[31]

Strategic litigation is important because it can be used to challenge policies or practices that violate the human rights of people living with HIV or populations most at risk of HIV. Strategic litigation can be used to change laws or policies, to ensure laws and policies are enforced in a manner that is consistent with human rights, or to highlight gaps in the law that need to be addressed by

[27] *Ibid.*

[28] See *The HIV and AIDS Tribunal Compendium of Cases* available at http://www.kelinkenya.org/wp-content/uploads/2016/11/Compedium_HIV-AIDS-Cases_29-Nov-.pdf <accessed 2.12.2020>

[29] See *Compendium of Judgment for Judicial Dialogue on HIV, Human Rights and the Law in East and Southern Africa* available at https://www.undp.org/content/undp/en/home/librarypage/hiv-aids/compendium-of-judgment-for-judicial-dialogue-on-hiv--human-right.html <accessed 2.12.2020)

[30] Open Society Foundations (2016) *Advancing Public Health through Strategic Litigation: Lessons from Five Countries* June 2016, New York, NY, USA

[31] International Development Law Organization (IDLO) and United Nations Joint Programme on HIV/AIDS (UNAIDS) (2010) *Scaling Up HIV-Related Legal Services Report of Case Studies: Ukraine, Kenya, and India*

legislators.[32] Beyond impacting laws and policies, strategic litigation can change practice, breathing life into existing legal rules never implemented. While cases may target a particular law, policy, or practice, indirect impacts beyond a particular court decision on future cases, other branches of government, and the public record may be just as important. Strategic litigation can also shape public discourse on issues relevant to health through development of the court's record, integration of expert testimony, and the use of media advocacy. Strategic litigation, in turn, can galvanize social movements, creating events around which mobilization and media engagement can occur and facilitating coalition-building and the development of leadership.[33]

KELIN adopted the use of strategic litigation cognizant of the role that laws and policies play in the HIV response. This role was aptly described by the Global Commission on HIV and the Law which noted that: *"The law alone cannot stop AIDS. Nor can the law alone be blamed when HIV responses are inadequate. But the legal environment can play a powerful role in the well-being of people living with HIV and those vulnerable to HIV. Good laws, fully resourced and rigorously enforced, can widen access to prevention and health care services, improve the quality of treatment, enhance social support for people affected by the epidemic, protect human rights that are vital to survival and save the public money."* Laws focused on protecting the rights of marginalized populations are critical for HIV prevention and treatment.

The role of the law and human rights in the HIV response was first considered by the 1989 International Consultation on AIDS and Human Rights organized jointly by the then United Nations Centre for Human Rights and the World Health Organization. Increasingly the international community recognized the need for elaborating how the existing human rights principles apply in the context of HIV and how governments can protect human rights and public health in the context of HIV. International guidelines on HIV and human rights to guide governments were developed. The issue was further emphasized at the June 2011 High Level Meeting on AIDS, held in New York, which commemorated 30 years since the emergence of the global AIDS epidemic, where world leaders reiterated their commitment to achieving universal access to HIV prevention, treatment, care and support by 2015 and eliminating discrimination against people living with HIV. In the 2011 Political Declaration on HIV&AIDS, adopted at this meeting, governments including Kenya committed specifically to address laws and policies that "adversely affect the successful, effective and equitable delivery of HIV services and consider their review[34]

3.2.Strategic cases litigated by KELIN in the HIV response

Strategic litigation is a powerful tool to advance rights, hold governments accountable and ensure compliance with human rights obligations. KELIN has used strategic litigation on HIV and TB related issues to: (i) advocate and increase public awareness on HIV and TB related rights; (ii) provide a better interpretation and application of HIV and TB related provisions in law; (iii) challenge government policies that violate/threaten the human rights of PLHIV; and (iv) set precedents that will positively impact future HIV related litigation.

[32] *Ibid.*

[33] Ezer, T., & Patel, P. (2018). Strategic Litigation to Advance Public Health. *Health and human rights*, *20*(2), 149–160.

[34] KELIN (2014) *Punitive laws and policies affecting HIV responses in Kenya* Nairobi, Kenya.

KELIN has successfully used strategic litigation to overturn negative policies and advance HIV related human rights as discussed below:

3.2.1. Challenging discrimination of persons living with HIV

The case of *Midwa vs. Midwa Case No. 197/2000 EALR [2002] 2 EA 453(CAK)* dealt with the question of divorce where one spouse had tested HIV positive. A ruling by the Court of Appeal on an interlocutory ruling by the High Court Judge on this matter helped develop jurisprudence to the effect that the HIV status of a person cannot be used to deny him/her custody of her children and affirmed the principle of non-discrimination on the basis of one's HIV status. The case has been a great learning point around the issues of stigma and HIV and how the same have played in court decisions demonstrating the limited understanding of the subject matter at the point of time. KELIN has utilized this case in many of its workshops to demonstrate the legal and ethical issues that HIV raises in the context of the law.

Given the absence of health status as a ground for non-discrimination in the repealed Constitution, case law was utilised to determine and set precedent on matters relating to discrimination of persons living with HIV. The leading case on this matter is *JAO vs. Home Park Caterers Limited, Dr Primus Ochieng and Metropolitan Health Services Limited HCC No. 38 of 2003*.[35] This was a case that was challenging the unlawful dismissal and testing of a HIV positive waitress. The Plaintiff, J.A.O., was a woman living with HIV. The Defendants were her employer (Home park Caterers), her doctor and hospital. The Plaintiff claimed the doctor and hospital subjected her to an HIV test without her consent, in violation of her constitutional right to privacy. She further claimed that the doctor disclosed her HIV status to her employer without her knowledge or consent, in violation of her constitutional right to confidentiality and the doctor's statutory duty of confidentiality. The Plaintiff also claimed that she was unlawfully terminated from her employment on the basis of her HIV status. The Defendants asked the Court to dismiss the suit for failure to state a reasonable cause of action. The Defendant employer claimed the reason for the Plaintiff's termination was prolonged absenteeism on medical grounds. The Defendant doctor claimed she did not disclose the Plaintiffs HIV status to the Defendant employer and that the Plaintiff was not tested for HIV without her consent. Though the case was concluded by consent and the petitioner received compensation for the violation of her human rights, the court made the following pronouncements that have shaped the jurisprudence on HIV:

i. Testing of an employee or prospective employee for HIV without his/her informed consent constitutes invasion of her right to privacy
ii. The disclosure of an employee's HIV status to the employer without the employees consent is unlawful
iii. The termination of employment on grounds of an employee's HIV status is unlawful

An interlocutory ruling in this case also allowed the use of pseudo names by persons who are living with HIV, to help protect their identity and maintain their confidentiality during court proceedings.

[35] See also J.A.O. v. Homepark Caterers LTD, et al. *Global Health and Human Rights Database* available at https://www.globalhealthrights.org/africa/j-a-o-v-homepark-caterers-ltd-2-ors/ <accessed 1.12.2020>

3.2.2. Protection of right to privacy of PLHIV

In 2016 the court made a decision to protect the right to privacy of persons living with HIV. This was in the case of *KELIN & 3 others v Cabinet Secretary Ministry of Health & 4 others [2016] eKLR - Petition 250 of 2015.* In that case, KELIN challenged in court a directive issued by the President on 23 February 2015 to County Commissioners, to work with County Directors of Education and Medical Services, to collect up-to-date data and prepare a report on: all school going children who are HIV positive and information on their guardians; number of expectant mothers who are HIV positive: and number of breastfeeding mothers who are HIV positive. This data was to be collected in a prescribed matrix that would directly link the above mentioned persons with their HIV status, thus putting them at a risk of being stigmatized and discriminated against. The court in a landmark judgment declared the presidential directive unconstitutional since the implementation of the directive violated the rights to privacy and the best interests of the child. The government was ordered to; within *45 days codify the names collected as a result of the directive and the same be stored in a manner that does not link the names of persons named therein with their HIV status in a public document.*

In a key move, KELIN engaged the then UN Special Rapporteur on the right to health, Mr Anand Grover, to file an amicus curiae brief that outlined Kenya's obligations under international human rights law. Mr Grover's brief was a powerful intervention in support of KELIN's case and influenced the court's decision to declare the President's HIV list unconstitutional. KELIN publicised and mobilised popular support for the case through a media campaign driven by the hashtag *#UhuruHIVList.*

This was a positive judgment with an impact in protection of right to privacy and confidentiality of persons living with HIV. Communities and civil societies have used the judgment to advocate for enactment of privacy regulations contemplated under section 20 of the HIV and AIDS Prevention and Control Act (HAPCA) (2006). The privacy regulations are currently in development and the relevant government agencies developing them have meaningfully engaged civil society in the process

3.2.3. Criminalization of HIV

In 2015, the court declared as unconstitutional a provision of HAPCA whose effect was to criminalise persons living with HIV, HIV exposure and transmission. This was in the case of *Aids Law Project v Attorney General & 3 others [2015] eKLR* where the high court considered the constitutionality of section 24 of the HIV and AIDS Prevention and Control Act, 2006. Section 24 of the Act provided:

> *"(1) A person who is and is aware of being infected with HIV or is carrying and is aware of carrying the HIV virus shall—*
>
> *(a) take all reasonable measures and precautions to prevent the transmission of HIV to others; and*
>
> *(b) inform, in advance, any sexual contact or person with whom needles are shared of that fact.*
>
> *(2)A person who is and is aware of being infected with HIV or who is carrying and is aware of carrying HIV shall not, knowingly and recklessly, place another person at risk of becoming infected with HIV unless that other person knew that fact and voluntarily accepted the risk of being infected.*

(3)A person who contravenes the provisions of subsection (1) or (2) commits an offence and shall be liable upon conviction to a fine not exceeding five hundred thousand shillings or to imprisonment for a term not exceeding seven years, or to both such fine and imprisonment."

In this case, the High Court held that section 24 of the *HIV and AIDS Prevention and Control Act, No. 14 of 2006* was unconstitutional for being vague and lacking in certainty. And that the same was also overbroad and was likely to violate the rights to privacy as enshrined under Article 31 of the Constitution.

KELIN has in 2018, filed a similar challenge to Section 26 of the Sexual Offences Act. The petition challenges the constitutionality of Section 26 of the Sexual Offences Act which criminalises deliberate transmission and or exposure of a sexually transmitted disease. Despite global consensus amongst experts and institutions such the World Health Organization and UNAIDS that laws criminalizing HIV transmission and exposure weaken the ability of governments to end the AIDS epidemic, section 26 maintains such a criminalization provision. Section 26 of the Sexual Offenses Act creates a range of crimes that carry a mandatory minimum sentence of 15 years' imprisonment. Kenya has committed in international agreements and domestic strategic plans to eradicate such discriminatory laws yet has failed to do so and the Office of the Director of Public Prosecutions continues to charge and prosecute people with these offences. KELIN also launched the #positivejustice campaign to sensitize the public on this case.

3.2.4. Access to essential medicines for PLHIV

In 2012, the court made a landmark decision that protected the right to access medicines for persons living with HIV. This was in the case of *P.A.O & 2 Others v. Attorney General [2012] eKLR* where sections 2, 32 and 34 of the Anti-Counterfeit Act 2008 were challenged. The Petition argued that the provisions were likely to affect access to affordable and essential drugs and medicines including generic drugs since generic medicines were classified by the Act as counterfeits. The petitioners argued that Section 2 of the Act confused generic drugs with counterfeit medicine and if implemented, the Act would inflict civil and criminal penalties on generic medicine manufacturers and severely restrict access to affordable medicine in Kenya. Such restrictions would violate the petitioners' right to life, health and human dignity under the Articles 26(1), 28 and 43 of the Constitution and Article 12 of the International Covenant on Economic, Social and Cultural Rights.

The High Court ruled for the petitioners and declared Sections 2, 32 and 34 of the Act unconstitutional. It held that the definition of "counterfeit" in the act would likely to be read as including generic medication and was therefore likely to adversely affect the manufacture, sale, and distribution of generic drugs. This in turn would hamper the availability of the generic drugs and pose a threat to the petitioners' right to life, dignity and health under the Constitution. The court agreed that the Sections 2, 32 and 34 of the Anti-Counterfeit Act "threatened to violate the right to life of the petitioners as protected by Article 26 (1), the right to human dignity guaranteed under Article 28 and the right to the highest attainable standard of health guaranteed under Article 43 (1)."

KELIN with other organizations launched a public campaign to sensitize the public that generic medicines were not counterfeit. Some of the individual petitioners in this case were community

members who had been trained by KELIN on HIV, human rights and the law. They still continue to champion for the human rights of PLHIV.

This case is significant given that a vast majority of people living with HIV and AIDS in Kenya rely on generic drugs for their survival. The ruling is a major victory for millions of Kenyans who depend upon generic medicine for their treatment. The Court cited in its opinion the International Covenant on Economic, Social and Cultural Rights and holds that the state's failure to promote conditions in which its citizens can lead a healthy life means that it has violated, or is likely to violate, their right to health. Furthermore, the judgment emphasizes that individual intellectual property rights should not supersede the right to life and health.[36]

3.2.5. Criminalization of people with TB - *Daniel Ngetich and 3 others* v *The Attorney General* PT 329 of 2014.

On 12 August 2010, Henry and Patrick, residents of Kenya's Nandi County, were arrested for default — not on a debt, but on a disease. They were charged with failing to maintain their prescribed medical treatment for tuberculosis. Daniel and Patrick were arraigned before the principal magistrate at Kapsabet Court. Henry, in poorer health, was admitted as a patient at Kapsabet District Hospital.

Daniel and Patrick were convicted and sentenced to eight months in prison. Behind bars, they slept on the floor without bedding for over a week, were closely confined with other inmates and weren't given the balanced diet required by TB patients on medication. They served 46 days of their prison terms before KELIN and other civil society groups intervened to have them released. The petitioners were incarcerated under Section 27 of the 1921 Public Health Act for interrupting their TB medication.

As outrageous as these cases may seem, they are far from isolated incidents. There have been many others, both reported and unreported, in which the Public Health Act was invoked to incarcerate TB patients who defaulted on their medications. Such arrests are in clear violation of the World Health Organization's guidelines, which state that when involuntary isolation or detention of a patient is absolutely essential, it must never be implemented as a form of punishment.

KELIN was among the petitioners who launched a petition in the Constitutional and Human Rights Division of the High Court to challenge this practice. On 24 March 2016 the High Court in Nairobi declared that the practice of detaining persons with TB in prison was both unlawful and unconstitutional. The court ordered the government to issue a circular within 30 days to public health officials to the effect that such detention in prisons was not sanctioned by the law. This circular has since been issued. The court further ordered the government to develop a policy within 90 days on involuntary confinement of persons suffering from infectious diseases. This has also been complied with. The judgment put a stop to the arrest and imprisonment of tuberculosis patients by ensuring that future isolations will be handled in a patient-centred manner that respects human rights.

[36] P.A.O. and 2 Others v. the Attorney General & Another *ESCR-Net* available at https://www.escr-net.org/caselaw/2013/patricia-asero-ochieng-and-2-others-v-attorney-general-another <accessed 3.12.2020>

As the case progressed, KELIN developed and launched a media campaign to support the litigation entitled "TB is Not a Crime." The campaign involved mobilizing affected communities and engaging the media to raise awareness about the case and the challenges facing people with TB in Kenya. Following the court victory, KELIN created a video showcasing the campaign and litigation. The video featured powerful interviews with the Ng'etich and Kirui in which they discussed the difficulties they faced in adhering to treatment, difficulties which led to their imprisonment.

This case was a success in given that the Ministry of Health complied with all the court orders. The Ministry issued a circular and further developed an isolation policy that is rights-based.[37] The case has further been referenced in Supreme Court in the case of *Mitu-Bell Welfare Society v. Kenya Airports Authority* as part jurisprudence to persuade the court on the need and effectives of structural remedies. The Mitu-Bell case arises out of a claim made by Mitu-bell Welfare Society against Kenya Airports Authority (KAA) and Commissioner of Lands in regard to the eviction of the members of Mitubell Welfare Society from the land they lived on that was owned by the Kenya Airport Authority. The High Court had found that the eviction was unlawful and granted post-judgment supervisory orders on the procedures to be followed in evicting members of Mitubell Welfare Society by KAA. Parties were required to report to the court on the implementation of this court order. On appeal, the Court of Appeal set aside the High Court judgement. The court found that a court does not have supervisory powers over its orders after the delivery of the judgment. The Daniel Ngetich case was cited as an authority where the High Court granted structural interdicts as an appropriate remedy that proved effective. The Court, having found a violation of the fundamental rights and freedoms, directed that the Ministry of Health take certain detailed steps. The respondent, the Ministry of Health undertook the steps as ordered – issued the circular as directed, developed the Isolation Policy as ordered and the Attorney General filed the affidavit detailing the policy measures undertaken by the government almost three years after the judgment was delivered.

3.2.6. Forced and coerced sterilization of women living with HIV

Forced or coerced sterilization of women living with HIV is a troubling trend that has been recorded in Kenya, Uganda, Namibia, Botswana, and South Africa. It is an injustice that for most victims is harder to accept than their HIV status. KELIN in 2014 filed a constitutional petition to challenge this practice and seek justice for those affected. Petitions 605 and 606 of 2014 were filed in 2014, and challenge the forced and coerced tubal ligation of five women living with HIV. The cases are pending in court.

3.2.7 Safeguard the right to work and fighting discrimination in the work place

In the case of *VMK v. Catholic University of Eastern Africa (CUEA),* [2013] eKLR the Claimant had been an employee of the Respondent since the year 2000 when she joined as a casual employee in the position of a telephone operator and was earning Kshs. 7000 as basic pay without benefits. There were two male employees in the same position employed on permanent and pensionable terms. In 2003, the Claimant responded to an internal job advertisement, was shortlisted, interviewed and was recommended for appointment and invited to discuss the new terms of service but her hopes were quickly dashed when the Respondent received the results of an HIV test, done

[37] National Tuberculosis, Leprosy and Lung Disease Program (NTLD) (2018) *Tuberculosis Isolation Policy*

without the knowledge, consent or authority of the Claimant. The test was done as a pre-requisite for taking up the job and HIV was not among the tests that was to be conducted based on the Medical Examination form which she was given by the Personnel department. The Claimant was not counseled prior to the disclosure of the results to her, and the Respondent went ahead to share the results with her colleagues and superiors in the Human Resource Department. The Claimant continued to work for the Respondent until 28th September, 2007 when she was offered a one year contract earning Kshs. 26,171 without benefits. The Respondent kept her on short and progressively shorter contracts with unequal terms due her HIV status; refusing her paid maternity leave followed by an immediate termination of employment upon return from the unpaid maternity leave. On the 8th November, 2013, the court delivered its judgment in the matter. This is the court determined that:

- The initial discrimination appears to have been for no other reason but that the Claimant was a woman and was targeted to be employed on unequal terms for equal work. The court found that the Claimant was remunerated differently for equal work for a period of seven (7) years.
- The court held that an employee or prospective employee may not be medically unfit merely by virtue of having been infected by HIV. The Respondent: grossly erred in refusing the Claimant herein employment on a permanent basis on the basis of her HIV status; grossly breached the Claimants right to employment and equal treatment by subjecting her continuously to casual employment and inferior remuneration purely on the basis of her HIV status. The Claimant was awarded Kshs. 6,971,346/=.

4. Challenges

Some of the challenges faced in utilizing the access to justice model discussed above include: (i) the long period that it takes to conclude cases. For instance, the cases challenging the forced and coerced sterilization of women living with HIV were filed in 2014 and are still pending in court. (ii) it is also a challenge to get clients who are not afraid to litigate or have their identity exposed especially in the stigmatizing environment of HIV. (iii) strategic litigation is costly and as such there is a challenge around funding with most donors expecting quick results yet litigation takes time.

5. Conclusion and Lesson learnt

In conclusion, KELIN learned at least three key lessons: First, that strategic litigation, coupled with community mobilization and media engagement, is an effective tool in the face of gaps in HIV- and TB-related law and policy. Second, affordable legal services are essential. Pro bono legal services allow people living with HIV to challenge human rights violations and contest discriminatory laws and practices. Third, community members can be directly involved in realizing legal reforms.