

POSITIVE HEALTH, DIGNITY AND PREVENTION IN KENYA:

FINDINGS AND RECOMMENDATIONS FROM STUDIES
LED BY PEOPLE LIVING WITH HIV



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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARVs	Antiretroviral medication
CS	Civil Society
CBO	Community-Based Organisations
CCM	Country Coordinating Mechanism (Global Fund for AIDS, TB and Malaria)
CSO	Civil Society Organisation
DFID	(UK Government) Department for International Development
HIV	Human Immunodeficiency Virus
GIPA	Greater Involvement of People Living with HIV
GNP+	Global Network of People Living with HIV
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
KANCO	Kenya AIDS NGO Consortium
LTA	The HIV Leadership through Accountability Programme
M&E	Monitoring and Evaluation
MSM	Men who have Sex with Men
NACA	National AIDS Coordinating Agency
NEPHAK	National Empowerment Network for People with HIV/AIDS
Network	National network of PLHIV
NGO	Non-Governmental Organisation
PHDP	Positive Health, Dignity and Prevention
PLHIV	People Living with HIV
PwP	Prevention with Positives [Preferred terminology is Positive Health, Dignity and Prevention]
PUD	People who use drugs
SRHR	Sexual and Reproductive Health and Rights
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
VCT	Voluntary Counselling and Testing

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Introduction

The National Empowerment Network of People Living with HIV and AIDS in Kenya (NEPHAK) was established in 2003 to unite support groups of PLHIV in Kenya into a formidable force to counter the impact of HIV on their members' lives and those of their loved ones. NEPHAK's mission is to promote greater involvement of PLHIV at all levels of the HIV response in Kenya with the overall goal of improving the quality of life of PLHIV. The vision of NEPHAK is to see a nation where PLHIV are at the frontline in the fight against HIV and AIDS and where their rights are recognized and respected to support their meaningful involvement in national efforts aimed at achieving an 'AIDS and TB Free Society'.

NEPHAK was the very first national network of PLHIV to join the HIV Leadership through Accountability (LTA) Programme, which strengthens the capacity of national networks of PLHIV to develop an evidence base, through research, for more effective advocacy. As a participant in the LTA programme, NEPHAK implemented several studies modelled on five evidence-generating tools, developed by the Global Network of People Living with HIV (GNP+) and its partners. The findings and recommendations of these studies are informing evidence-based advocacy for policy change in order to enhance the Kenyan HIV response and move towards achieving universal access to HIV prevention, treatment, care and support.

In January 2011, after consultations with PLHIV from around the world, GNP+ and UNAIDS also released Positive Health, Dignity and Prevention (PHDP), a framework that promotes the rights, health and empowerment of PLHIV to take on leadership roles in HIV prevention responses, which create a more conducive environment for HIV prevention efforts. Although NEPHAK is already engaged in a number of prevention efforts supporting PLHIV, the effectiveness of HIV prevention work in Kenya could be strengthened with the integration of the components of PHDP which promote NEPHAK's dual aims of respect for the human rights of PLHIV and improving their quality of life.

Advocacy for PHDP will require evidence on several aspects of the HIV response at once, some of which may have already been collected by the research NEPHAK conducted for LTA programme. This paper mainly reviews the findings and recommendations of the research pertinent to PHDP in Kenya, in order to better prepare for nationwide PHDP campaigning. Additionally, some activities implemented by NEPHAK as part of their initiatives to promote positive health dignity and prevention (PHDP) in Kenya¹ have been mentioned.

¹ Part of NEPHAK's resolve and struggle has been to ensure that the national language of prevention with positives (PwP) be replaced with Positive Health, Dignity and Prevention which is more acceptable to PLHIV.

Positive Health, Dignity and Prevention

Positive Health, Dignity and Prevention (PHDP) is a policy and advocacy framework that recommends addressing the human rights, health and welfare needs of PLHIV holistically, as a critical step to more effectively engage them. In fact, a focus on the health and dignity of people living with HIV also contributes to the health and well being of their partners, families and communities, and in and of itself, should act as significant steps towards HIV prevention.

PHDP is a distinct shift from ‘prevention with positives’ (PwP)² projects being rolled out in a number of countries, including Kenya, which are narrowly targeted at changing the behaviour of people who know that they are HIV-positive, with limited consideration of how failure to meet their needs for social support, human rights and treatment of PLHIV can undermine HIV treatment and prevention efforts. PHDP calls for programmes to recognise the value of PLHIV as partners, leaders and implementers of the HIV response, including HIV prevention. Programmes should empower and capacitate PLHIV and not simply treat them as patients, passive targets or worse, as vectors of transmission. PLHIV should be seen, not as part of the problem, but as an integral part of the solution.

PHDP argues that in order to reach and engage PLHIV in the HIV response, including prevention efforts, national programmes must address the following points:

1. Establish a legal and policy environment where it is safe to live openly as an HIV-positive person (if he or she so chooses) free from the fear of HIV stigma, discrimination, gender violence, displacement or other human rights violations;
2. Focus on the health and well-being of PLHIV by providing universal and convenient access to essential treatment, care and support services, including confidential HIV counselling and testing services. A focus on high quality health services is needed to improve and maintain the well-being of those who test HIV-positive, including timely antiretroviral therapy (ART);
3. Provide the tools and services to enable HIV-positive people to exercise their full sexual and reproductive health rights, while protecting their partners and infants from HIV;
4. Develop policies and support services addressing the social and economic factors that undermine the health and dignity of PLHIV such as poverty, food insecurity, lack of access to educational opportunities or employment, gender inequality and the discrimination and oppression of key marginalised populations at risk of HIV (including men who have sex with men, people who use drugs, migrants, prisoners, young people, women and sex workers);
5. Tailor non-judgmental services to reach out to the underserved key populations.

HIV prevention services need to include PLHIV, including key populations, in conception, design and implementation of the services targeting them. Otherwise, programmes may fail to consider critical fears or needs of the population and may even stigmatise their targeted population and limit the uptake and effect of the service. For instance, prevention initiatives focused solely on the responsibility of PLHIV to prevent HIV transmission to others may inadvertently send out the message that ‘PLHIV are solely responsible for HIV transmission’ and lend support to efforts to criminalise HIV-exposure/transmission

² NEPHAK has been part of the Technical Working Group on PWP at the National AIDS and STDs Control Programme (NAS COP).

and ‘scape-goat’ key populations. Such an approach can backfire and actually increase the transmission of HIV by chasing the targeted population groups away from HIV testing and health services. HIV treatment and prevention interventions will never achieve their optimal desired results in an environment where the human rights of PLHIV are not respected or where their social and health needs are not being met, and when they are not engaged in the services that affect them.

The PHDP Policy Framework describes some of the core programmatic components that could help create a more enabling environment for the success of HIV treatment and prevention services; and these encompass the full range of health and social-justice issues for PLHIV (see appendix B). Few countries have policies, programmes or services in place performing well enough to reach the goals of PHDP and advocacy is needed on several fronts at once to address the wide range of issues and promote the engagement of PLHIV across the HIV response.

National advocacy should be tailored to address the most significant barriers to PHDP in Kenya and to take advantage of opportunities that already exist. But tailoring the campaign to the Kenyan context requires being informed by current and accurate information on:

1. The most pressing health and dignity needs for HIV-positive people living in Kenya; and
2. The strengths and weaknesses of existing national policies, programmes or services including:
 - a. Whether there are key programmatic areas that have been neglected (such as programmes addressing key populations).
 - b. Examples of best practice where they exist — such as initiatives demonstrated to improve the health and well-being of PLHIV and their engagement in HIV prevention efforts — that can be scaled-up as part of the national PHDP framework; and
 - c. When there are critical gaps in knowledge, such as the absence of data on the positive health, dignity and prevention needs of key populations.

Many of the values and programme components of the PHDP Framework overlap with issues explored by five evidence-gathering tools. Together, their combined findings provide an insight of where Kenya is with regards to the values and programmatic components for PHDP.

Five Evidence-gathering tools used in HIV Leadership through Accountability Programme

PLHIV should set the agenda for any advocacy that affects them. However, in order to truly improve conditions for people living with HIV in Kenya, advocacy agendas should be based upon evidence documenting what the local conditions are. This means understanding how Kenyans living with HIV have experienced their lives with HIV, including their experiences of accessing essential services, and what those experiences say about the quality or performance of the Kenyan national HIV response.

NEPHAK, through the HIV Leadership through Accountability (LTA) Programme implemented five evidence-gathering tools in partnership with civil society. The research, based on five standardised tools, aims at strengthening evidence in five key areas:

1. The level of involvement of people living with HIV in the Kenyan national HIV response, using the **GIPA (Greater Involvement of People Living with HIV) Report Card**: This tool measures the meaningful engagement of PLHIV in the decisions and programmes that affect them by interviewing key individuals in international NGO's and technical assistance organisations, and in the government and other major stakeholders in the national HIV response.
2. HIV-related stigma and discrimination, using the **People Living with HIV Stigma Index**. This involved conducting a large survey of PLHIV in Kenya to measure trends in stigma and discrimination within the social environment, family, seeking employment and the workplace; how stigma, including internalised stigma, and discrimination affect access to health care services, HIV testing and treatment, or having children and internalised stigma impact on the lives of people living with HIV; and whether PLHIV in Kenya are aware of their rights. In addition, follow up work on stigma index has been done through interviewing sex workers in Nairobi and religious leaders in the coast region of Kenya in partnership with K-WVORIC and the Catholic Church. These studies are generating information that would eventually enrich the evidence gathered earlier around HIV associated stigma.
3. Documenting and analysing human rights violations against Kenyan PLHIV on the basis of their HIV status or presumed status, with the **Human Rights Count!** and immediate follow up with PLHIV in the Rift Valley Province with support from the National AIDS Control Council (NACC).
4. Documenting and analysing the access and quality of services supporting the rights of PLHIV to have healthy, satisfying sex lives and to have children — using the **Sexual and Reproductive Health and Rights Guidance Package**. In the case of Kenya, NEPHAK adapted the tool to assess the experiences and needs of PLHIV making use of vertical transmission services in Nairobi.
5. The **Global Criminalisation Scan** documented and analysed cases relating to criminalisation of HIV transmission and exposure, and of laws that specifically restrict the rights of PLHIV. The methodology involved documenting laws, judicial practices and cases studies.

Goals and Methodology

This report reviews the combined findings and recommendations of research conducted by NEPHAK in order to establish the steps required to create a Positive Health Dignity and Prevention (PHDP) Framework for Kenya.

It explores whether the evidence contained within the five reports published by NEPHAK to describe the country's progress towards achieving the values of PHDP and to document the existence and performance of the programmatic components (policies, services and initiatives) are ready to be integrated into a national PHDP framework, and then highlights recommendations most likely to improve the health and dignity of PLHIV in Kenya.

A thematic review was performed of the LTA report findings, conclusions and recommendations to search for any significant reference to the key PHDP themes and issues, as described by the PHDP Policy Framework. Observations were made on any topic which was not addressed in the LTA research, or when there was little information regarding a population's health and dignity needs, or when the performance of a programme or service could not be assessed, or could not be determined due to the quality of the available data, or due to limitations in the LTA study methodology.

The desk review also includes references to a few important developments have been reported at recent LTA meetings or on the LTA website (www.hivleadership.org) and other published relevant information. The report also identifies some of the limitations of the review when other sources of information may need to be consulted, or additional research needs to be performed in order to provide a more comprehensive evidence base.

The following section of the report summarises the key findings of the review, and describes the key barriers and opportunities to advance PHDP as suggested by the thematic analysis and the action steps for PHDP advocacy that can be drawn from the LTA research recommendations.

Realising the Principles and Values of PHDP

In the last several years, there have been positive developments in key aspects of the multisectoral HIV response in Kenya — with increasing engagement of PLHIV in policy making and service delivery, the expansion of HIV treatment services reaching many PLHIV with the Kenyan Government also contributing directly to the provision of antiretroviral therapy and the introduction of a legislation framework at least partially addressing the human rights of PLHIV. Another positive development has been the unveiling of an expanded HIV prevention platform recognizing the HIV prevention needs of PLHIV.

However, NEPHAK's LTA research suggests that Kenya has a long way to go, before someone going for an HIV test can be confident that — if they test HIV-positive — they will not face stigma and discrimination, lose their job, or have difficulty accessing all the necessary treatment, care and support services, including sexual and reproductive health services.

In other words, there have been steps in the right direction towards meeting some of the principles and values of PHDP in Kenya, although implementation has only just begun.

On the positive side, PLHIV are seen as more than just 'patients' in Kenya, according to the respondents interviewed in the GIPA Report Card — with some playing leading roles in community sensitisation and mobilisation, and working as community health workers, adherence counsellors, HIV testing counsellors or home-based caregivers; while others represent PLHIV at national or local level in policy making or programme coordination. However, while the principle of GIPA is accepted, actual meaningful involvement is low in practice .

Nevertheless, Kenya falls short of the principles of PHDP in relation its approach to HIV prevention. Although there has never been any prosecutions, the vague insinuation for prosecution for 'knowingly and recklessly' infecting another person, is criminalised in legislation that form part of the laws of Kenya under the HIV and AIDS Prevention and Control Act (HAPCA)³. Another policy document that reflects the unnecessary discrimination of PLHIV is the Sexual Offences Act, which in part prescribes additional and more punitive punishment for sexual offenders who are found to be HIV positive. In addition, HIV prevention services targeting PLHIV in Kenya are still based upon the 'PwP' approach, which implies that the responsibility for HIV prevention is dependent upon HIV-positive partners (as opposed to being a shared responsibility). However, this may partly be due to the influence of PEPFAR funding (CDC/ USAID through the National AIDS and STIs Control Programmes (NASCOP) supported the training of NEPHAK members as 'Community PWP trainers of trainers.'). The leadership of NEPHAK had to provide an orientation to the trainers on principles and values of PHDP.

Although policies have been introduced to address sexual and reproductive health needs of PLHIV, respondents in the GIPA Report Card said few PLHIV have adequate access to SRH services in Kenya (see below).

³ Section 24 of the HAPCA states in part: "that a person who being aware that they are HIV positive but who 'knowingly and recklessly' places another person at risk shall be liable for prosecution".

Even though Kenya is moving towards developing a supportive and protective policy and legal environment, it has yet to dramatically alter the ‘environment’ experienced by the majority of PLHIV. Stigma and discrimination against PLHIV remain widespread; although HIV prevention, treatment and care services are expanding, people do not have access to high quality and reliable HIV treatment and care. Worse, being over-reliant on external support to HIV treatment and care makes the supply of services and commodities unpredictable and unsustainable.

The health, dignity and engagement of PLHIV are often undermined by poverty, illiteracy, and gender inequality. However, there is little aid for PLHIV or their affected families in Kenya to mitigate the negative economic impacts of HIV or to address economic disadvantages and limited access to education that have made many, especially women, more vulnerable to HIV in the first place. Although the country has just unveiled a new constitution with an expanded Bill of Rights and robust provision on Social Protection, strategies and guidelines to support their implementation and realization are still missing. There has been no significant, formal, overall policy development since *Sessional Paper No. 4 of 1997 on AIDS in Kenya*. The HIV and AIDS Prevention and Control Act of 2006⁴, does not address overall policy issues, particularly those that matter to PLHIV and key populations⁵. Clearly, the provision of HIV outreach and services to key populations, such as men who have sex with men, sex workers and injecting drug users is made difficult by a punitive legal environment.

Although NEPHAK’s LTA research did document some of the special challenges that women living with HIV face with regards to meaningful engagement, or vulnerability to human rights violations, it did not have sufficient number of participants who self-identified as being from key populations to be able to assess how their needs were being met by programmes in Kenya.

⁴ Even as it is, the HIV and AIDS Prevention and Control Act (HAPAC) has certain offensive sections to PLHIV.

⁵ In this context, key populations comprise male and female sex workers, men who have sex with men and injecting drug users who are living with HIV

Core programmatic components and elements to support PHDP in Kenya

A number of the core programmatic components that could support PHDP in Kenya do exist at least in policy form, but have not yet established much of a track record. Given how more or less separate internationally funded HIV implementing NGOs operate in Kenya's HIV response, other programmatic elements are in place here and there, or are the result of the efforts of the civil society, non-governmental organisations and/or dependent upon international donor support. This is to be expected in a country where over 70% of support to the national response is from external partners.

However, it should be noted that the scope of the LTA research did not include an investigation of the complete range of the possible programmatic elements that could be part of a PHDP framework, or may have used more general terms for the core programme which could include some of these services/element. That being said, the absence of some terms, such as the lack of any reference to elements such as mental health services or treatment literacy suggests there are some critical gaps in the information the five LTA tools research may provide.

PLHIV empowerment

The GIPA Report Card generally suggested that there have been great strides forward in PLHIV empowerment and engagement in the national HIV response. This is partly because the 'principle of GIPA' had been 'officially' accepted — it had been endorsed by the National AIDS Control Council (NACC), and incorporated into the National HIV Strategic Plan and a separate National Guideline for Mainstreaming GIPA into the national response to HIV and AIDS also developed⁶. However, the survey also found that the level of PLHIV representation at policy-making level remained 'remarkably' low. Some respondents suggested that only the few PLHIV who came from economically, socially advantaged backgrounds were likely to become meaningfully engaged — and the vast majority of poorer PLHIV had never had access to education or the opportunity to develop the skills needed to be 'engaged' in a more professional capacity. Some respondents suggested targeted support for training and skills development may be needed to engage more PLHIV as leaders in policy making, programme planning and implementation. Nonetheless, when combined, fears of stigma and discrimination, and workplace discrimination were actually more commonly listed as obstacles keeping PLHIV from being more involved and taking on positions as openly HIV-positive.

Low levels of awareness of GIPA among PLHIV as well as some organisations involved in the HIV response are also barriers to uptake of GIPA. The National AIDS Control Council (NACC) and NEPHAK are actively working to address this — with support from UNDP and the UNFPA. The NACC supported the training of a number of National GIPA Facilitators drawn from NEPHAK member organizations. The trained facilitators have been engaged in the roll-out of the GIPA initiatives. NEPHAK also provides mentoring of young women leaders living with HIV, facilitating treatment and rights literacy workshops, and capacity building among other organisations and local networks of PLHIV affiliated to the network.

⁶ NEPHAK played a significant role in the development and launch of this document.

With National GIPA Facilitators trained with support of NACC and the trained trainers of Community PwP by PEPFAR through NASCOP, NEPHAK embarked on dissemination of national GIPA and PwP documents. This was also an opportunity in which to explain to NEPHAK members what HLTA programme was all about and make clarification on the difference in understanding between PwP and PHDP approaches. The dissemination was part of the NEPHAK PLHIV empowerment agenda and was undertaken in two regions where the LTA tools had not been administered (Western Kenya and Central Kenya) and three counties of one region where LTA programme was implemented (Coast region). The result of this dissemination work was an increased awareness of PLHIV leaders on GIPA and PHDP. There has also been continued dialogue on PLHIV leadership in these regions. The dissemination also included government officials drawn from NACC and NASCOP regional structures, and who also benefited from the clarification on the differences between PwP and PHDP. The dissemination exercise was supported by the United Nations Development Programme (UNDP) office in Kenya.

Gender Equality

The same social, economic and cultural obstacles that make women more vulnerable to contracting HIV also make them more prone to HIV-related human rights violations (gender-based violence). They've often had poorer access to education, and high rates of illiteracy, which makes their situation all the more difficult. Widowed women living with HIV may have no property ownership and inheritance rights (WPOIR) and could be cast out by the husband's family, often leaving them impoverished, and their children more vulnerable. The GIPA Report Card noted that Kenya's existing poverty reduction programme does not adequately address the differing impact that HIV has on women and girls.

The Kenya National AIDS Strategic Plan, recognizes that "ensuring HIV-related dimensions of gender inequalities are prioritized will be critical for the achievement of Universal Access goals." As such, there is a Gender Technical Committee (GTC) at NACC and NEPHAK is a member of the committee. In addition to NEPHAK's efforts to mentor women living with HIV, there are a number of networks of women living with HIV in Kenya, and civil society organisations such as the Centre for Reproductive Rights (CRR) and the Federation of Women Lawyers in Kenya (FIDA), which are advocating for the rights of women living with HIV.

The LTA research did not address every aspect of health services for women, but NEPHAK's SRHR package research found that despite the existence of good policies and guidelines, pregnant women in Nairobi were poorly served by the programme to prevent vertical transmission of HIV at the time the study was conducted, with many HIV positive women not attending antenatal clinic visits, registering high losses to follow-up and facilities experiencing supply problems⁷.

Health promotion and access

Descriptions of the quality and access to other HIV-related health services vary across the LTA research. In the GIPA Report Card, which took place in 2009, respondents cited the strained health system, staff shortages, and large workload were cited as concerns affecting access to HIV treatment and care services. There were complaints of limited access to CD4 Count testing and viral load testing services in public health facilities. Inadequate funding, supervision and coordination were characterised as leading to frequent stock-outs. The report concluded that, "examination of the progress on universal access to treatment shows that coverage remains inadequate, for various reasons, but that many respondents felt that greater involvement of PLHIV in managing these issues might speed up roll out and enhance continuity of supplies. In this matter, the application of the GIPA principle can be seen as a matter of life and death."

⁷ Kenya was undergoing difficulties with frequent stock-outs during the survey due to challenges with PEPFAR and the Global Fund which are the main financiers of HIV prevention and treatment programmes in the country.

The ART scale-up in Africa is rapidly expanding. The PLHIV Stigma Index reported NACC data suggest that between the years 2007 and 2009, the number of people on ART in Kenya almost doubled, with a total of 336,980 people on ART (70% who qualified for ART under guidelines at the time. This figure has since changed to less than 50% after the eligibility criteria have been reviewed from starting treatment when CD4 cells fall below 200 up to 350 cell/mm³). Participants in that survey reported good access to care services with a very high percentage on ART, however, since the population was largely drawn from health facilities, there would be a sampling bias in favour of people who have easier access to health services. It should also be noted that this survey was undertaken in Nairobi where health services tend to be accessible unlike in many rural parts of Kenya. To reach goals for universal access, the health service is decentralising HIV services to the primary health care level so that it is accessible in more remote rural settings. However, as this happens, care must be taken to make certain more remote sites are not more likely to suffer stock-outs, and that ways are found to provide similar support services (such as adherence support, etc) to what people receive at larger urban sites.

Human Rights

As noted earlier, Kenya has a new constitution with an expanded Bill of Rights and which provides for among other things the social and economic rights of individual. Health is now a right according to article 43 of the constitution. The section on Social Protection is impressive, implying that those vulnerable and marginalized shall have social safety nets to cushion them against the adverse effects of poverty and HIV. However, a lot more needs to be done to enable the poor and those living with HIV secure their rights. If anything, there are currently sections of the Law in Kenya which are discriminatory and criminalizing to key populations, including men who have sex with men, people who use drugs and sex workers.

The 2006 HIV and AIDS Prevention and Control Act (HIV Act) was commenced in 2008, but still has offensive sections. Under the same Act, the government has established a special HIV Equity Tribunal under the Attorney General's office for PLHIV who have experienced discrimination or human rights violations to seek redress and address other HIV related matters. The operation of this Tribunal has been constrained by lack of resources. The Tribunal will also need to be entrenched in the Kenyan Judicial system if it is to be of benefit to PLHIV and their families. Kenya has also passed legislation based upon the International Labour Organisation's Code of Practice on HIV and the World of Work.

Sexual and Reproductive Health and Rights

A couple respondents in the GIPA Report Card stated that policies had been developed to address sexual and reproductive health needs of PLHIV. It is not clear whether these policies are adequate, but the respondents said that they had not been widely implemented. Respondents said that few PLHIV were accessing these services partly because SRH services were not yet widely integrated into the same sites where people access HIV treatment and care (or vice versa). This means that the PLHIV who want to access those services, will need a referral to a facility where the non-HIV specialist staff may stigmatise them. There are still high levels of stigma in health institutions, directed towards PLHIV, particularly those who acknowledge being sexually active or to 'choosing' to have children, especially with a sero-discordant partner. In fact, the PLHIV Stigma Index mentioned cases of women being coerced into sterilisation, and 15% of female respondents said that their access to antiretroviral treatment was conditional on the use of certain forms of contraception. This is unlikely to change without targeted sensitisation and training.

Social and Economic Support Services

The LTA research did not specifically assess the full range of social and economic support services that may be available to PLHIV in Kenya, other than tangentially. Respondents in the GIPA Report Card noted that PLHIV often took the lead in development and delivery of support services including support groups/post-test clubs for PLHIV. The PLHIV Stigma Index noted that at least 30,000 of those on ART also receive nutritional support. Some regions where treatment and care services are receive technical support and funding from different international NGOs have local projects for income generation, community kitchen gardens etc.

The GIPA Report Card did mention that Kenya's poverty reduction strategy has not adequately targeted PLHIV, or considered their special needs, and called PLHIV to have more input in the strategy's development. Notably, the Kenyan National AIDS Strategic Plan now describes "plans to mainstream HIV into development planning, including poverty reduction strategies, national budget allocations, and sectoral development plans."

Measuring impact

NEPHAK recommends implementing the tools periodically, for example in another three years, to continuously gather data and ensure the data is part of the national M&E framework.

Key barriers to achieving PHDP in Kenya

1. Poverty, lack of access to education and training limit the empowerment and meaningful engagement of the majority of PLHIV in decisions affecting their lives
2. Stigma and discrimination remain entrenched, despite legislative protections, decreasing the incentive to get tested for HIV and serving as a barrier to accessing care
3. Official stigmatisation of PLHIV: Messaging in laws and programmes that stigmatise people living with HIV
 - a. The criminalisation of HIV transmission: Sections 24 of the 2006 HIV and AIDS Prevention and Control Act and section 26 of the Sexual Offences Act 2006, that make it a criminal offence to 'wilfully transmit' HIV, as currently worded, could lead to witch-hunts, unfair prosecution — and create a disincentive to get tested for HIV.
 - b. 'Prevention with positive' campaigns in Kenya inadvertently perpetuates the stigmatising message that people living with HIV spread HIV
4. Inadequate access to sexual and reproductive health services with outright hostility on the part of some health workers directed at PLHIV who wish to exercise the sexual and reproductive health rights
5. There is still significantly less than universal access to HIV prevention, treatment care and support, particularly in poor and remote regions where travel to the health facility is difficult
6. Weak health system: Mismanaged service delivery at some over-burdened, understaffed, and inadequately funding health facilities
7. Lack of financial aid or support services to mitigate the negative economic impacts of HIV or to address economic disadvantages that made people vulnerable to HIV infection in the first place
8. Laws mandating incarceration for engaging in sex work, homosexuality and drug use chase key populations away from HIV prevention and treatment services and fuel the epidemic
9. Gender inequality that makes women more vulnerable to contracting HIV, to stigma, discrimination, human rights violation, lack of inheritance rights when her husband dies leading to poverty
10. While a supportive policy and legal environment that is more conducive to PHDP in Kenya is now in place, implementation is hampered by lack of awareness on the part of PLHIV, as well as ignorance on the part of those who stigmatise and discriminate against them
11. Inadequate political will in addressing HIV, evidenced by inadequate effort to find domestic funding for HIV and over-reliance on donors.

Together, although policies and legislative protections have increased, these obstacles on the ground perpetuate an environment, where there is reduced willingness of people to test, or, if they do test positive, to disclose their status to their partner so that they can both to take care of their health and take precautions to prevent further HIV transmission. Likewise, fear of being stigmatised or that their status would become known if seen to be going to the clinic, act as a barrier to accessing health services for PLHIV, or to participate in projects or opportunities for their participation in the HIV response.

Together, these shortcomings increase the risk of poor health outcomes for PLHIV, and impact on HIV prevention in the country.

Opportunities for promoting PHDP in Kenya

Engaging in the LTA programme, and performing research has produced some opportunities to promote PHDP in Kenya.

The findings coming out of the LTA research reports have already had some impact, leading to, among other things, the greater involvement of people living with HIV in Kenya's national HIV response. Many of NEPHAK's advocacy points were incorporated into the National Strategic Plan 2009/10-2013.

NEPHAK's recognition increased as a result of the research and efforts to communicate their results, leading to the development of partnerships with organisations such as UNDP, UNAIDS and PEPFAR.

Ironically, NEPHAK has even been made a partner to provide training for the PEPFAR supported 'Prevention with Positives.' Being in that position as well as having one of its members on the gender technical committee at the National AIDS Control Council, may give NEPHAK leverage to advocate for expanding the programme to PHDP.

The opening of the HIV tribunal provides an opportunity to take cases of stigma and discrimination that NEPHAK has identified. Getting national media coverage of important cases could help educate the public and send the message out that discrimination and violating the rights of PLHIV is illegal, and could get the perpetrator into a court case.

Kenya could make significant strides on the path towards realising many of the objectives and goals of PHDP by implementing some of the key recommendations drawn from research conducted by NEPHAK.

Next steps for PLHIV and PHDP in Kenya

1. Work towards the realization of zero HIV-related stigma, discrimination and human rights violations while empowering and engaging PLHIV in HIV response;
2. Develop new campaigns or intensify existing interventions to address HIV-related stigma and discrimination within the family, community and institutional settings — and perhaps even more importantly to combat self-stigma among people living with HIV (PLHIV);
3. Develop a nationwide educational campaign for rights-literacy among PLHIV and inform them about how to access these services;
4. Build capacity among PLHIV to become meaningfully engaged at the level of programme coordination and policy making, by mobilising funding for training programmes, bursaries that expand their professional skills;
5. PwP programmes should be revised and expanded, as ‘interventions for couples’ — to promote a more balanced approach reflecting shared responsibility in prevention;
6. Integrate services to provide sexual and reproductive health services both to HIV-positive and serodiscordant couples, within a framework promoting PHDP;
7. Continue to the expansion and quality improvement of health services for PLHIV and key populations to achieve universal access, and the health related millennium development goals;
8. Demand increased funding from the national government for the health sector, which must continue to be strengthened to provide universal access to HIV counselling and testing, expanded and decentralised HIV treatment and support services, especially to provide access to rural setting; establishment of reliable and consistent supply of medicines and laboratory supplies, improve the quality of prevention of vertical transmission services with better integration with maternal child health services and access to appropriate sexual and reproductive health services.
9. Advocate for the repeal of laws criminalising HIV transmission and key populations: the Kenyan government should expunge legislation criminalising the transmission of HIV (sections 24 of the 2006 HIV and AIDS Prevention and Control Act and section 26 of the Sexual Offense Act 2006) and further needs to review other laws and regulations that hinders the HIV response such as the penal code which interferes with prevention efforts targeting men who have sex with men (MSM).

Conclusion

The review found the LTA research addressed the most critical questions regarding the national response to HIV and AIDS in Kenya. What was not covered so well was the range of other programmes or services at the state level, or from NGOs, community-based responses that might serve as models of best practice that could be scaled up country-wide.

There was also little information available on underserved populations, including adolescents, people who use drugs, MSM, prisoners, sex workers and other special vulnerable populations such as people with disability, or a very clear picture of what efforts are underway in the country to address gender issues.

The review recommends further investigation of the different regional networks, NGOs into local programmes to see whether some of the programmatic elements described in the PHDP report are available anywhere in the country. In more than one report, NEPHAK suggested conducting further research specifically targeting some of these key populations.

At a later stage, as programmes are put in place, it will be important to evaluate their performance and reach. The five LTA research tools are well placed to be part of the monitoring and evaluation of national strategic plan. The evidence gathered with a bottom-up approach and informed by community responses is a valuable contribution to the evidence-base on how to achieve Positive Health, Dignity and Prevention in Kenya.

LTA Programme: NEPHAK's research to develop an evidence base for advocacy

Performing its own research to collect data and evidence about the experiences and challenges confronting people living with HIV in Kenya has had a profound impact on NEPHAK's advocacy, according to Nelson Otwoma, National Coordinator/CEO, who represents the network on Kenya's country coordinating mechanism (CCM) to GFATM. "Now we have our own evidence that we are presenting on the table, and that is going to drive universal access."

NEPHAK began the research after joining the HIV Leadership through Accountability Programme. The research was based on five standardised tools, adapted and translated for use in the Kenyan context. The process and methodology conducting the trials are described elsewhere in the final reports. However, within the space of about 18 months, NEPHAK had concluded all five studies. Broadly, the studies reported that Kenya's response to its HIV epidemic has improved markedly over the last several years, however, there are still significant challenges confronting people living with HIV in the country.

GIPA Report Card

The GIPA Report Card concluded that there have been improvements in representation of PLHIV in the organisations and government bodies involved in Kenya's national HIV and AIDS response, but a number of those interviewed questioned how meaningful engaged and effectual these individuals were. Moreover, it noted that there were very few people 'openly' living with HIV placed in senior decision-making positions. The report suggested that this was not due to failure on the part the organisations or government to adopt the GIPA principle, but was mostly due to fear among PLHIV themselves that by accepting such positions might be put at risk of stigma or discrimination (actual and in the workplace). In addition, many people living with HIV come from poor backgrounds, and few have had access to education or training needed to develop the needed skills to participate or be employed in the HIV response. Thus, there are only a limited number of qualified candidates for such positions. Finally, there is a continuing lack of awareness of the GIPA principle among PLHIV.

The PLHIV Stigma Index

Stigma and discrimination persist at both the individual and society level in Kenya. While most reported that they had never felt excluded from gatherings, church or family activities, or been physically harassed or assaulted, more than half of the respondents reported being verbally insulted, harassed and/or threatened at some time, while 78.7% were aware of being gossiped about. However, a substantial proportion ~30-45% did report that more serious forms of stigma had occurred to them at least once. Roughly half of those who were physically assaulted for being HIV-positive were attacked by a member of their own household.

Similar percentages reported negative effects on relationships with their partners and other aspects of their social environment. Loss of job or income source when an employer finds out a person is HIV-positive continues to be rampant, affecting at least 40% of the population at least once, ~30% a few or more times. The impact of stigma on access to care and treatment is more difficult to assess in this study, since it drew most of its population from ART centres, thus sampling those who had been able to negotiate the healthcare system.

Self-stigma was profound in the study — roughly half said they had feelings of low self-esteem, blamed themselves or felt guilty about being HIV positive within the last 12 months. These feelings impacted on their choices: more

than half said they had chosen not to have more children, almost a third had decided not to have sex. Around one quarter had decided not to get married, or had withdrawn, isolating themselves from family and friends or avoiding social gatherings.

Very few respondents reported feeling that they had any power to influence matters affecting people living with HIV, even local projects for their benefit. In a perhaps related finding, those affected by severe stigma and discrimination found it difficult to fight back because of financial issues (the money or the time it would take to pursue justice), were intimidated by the bureaucratic red tape, had little confidence in their own abilities or in the available systems for seeking redress, or because someone had talked them out of it.

Human Rights Count!

The public's low level of knowledge about HIV is still one of the underlying causes for stigma and discrimination. As the report on the Human Rights Count! study noted 'discrimination on the grounds of one's HIV status constitutes a violation of civil rights.' Discrimination then leads to further human rights violations such as the rights to health, dignity, privacy, and freedom from degrading inhumane treatment. Once again, ignorance — in this case about the rights of PLHIV — led to the human rights violations, but NEPHAK concluded that was abetted by the absence of a legal framework upholding the rights of PLHIV.

Employment-related violations predominated in this study. At the same time, a large percentage of respondents did not report violations because they were unaware that their rights had been violated, or knew how they could seek redress.

The study report also notes that the same social, economic and cultural obstacles that make women more vulnerable to contracting HIV also make them more prone to HIV-related human rights violations. Their subservient role within the family gives them very little control over their lives. Poor access to education results in high rates of illiteracy, and makes their situation all the more difficult.

The SRHR Guidance Package

The study on SRHR found that pregnant women in Nairobi are poorly served by the programme to prevent vertical transmission of HIV. At least a quarter of the pregnant women do not attend antenatal clinic visits where the programme is operating and this is not being addressed adequately by the health system. Low enrolment, high loss to follow-up, supply and commodity problems, poor adherence to antiretroviral prophylaxis make the effectiveness of the programme questionable at the population level.

Routine 'opt-out' HIV testing and couples counselling and testing has increased uptake of HIV testing — and the respondents felt that it was particularly important to get the male partner's involvement.

The programme has not yet engaged non-medical lay-counsellors, expert patients and mentor-mothers who have proven so essential to the effectiveness of PVT programmes in other settings by providing psychosocial support for the pregnant women living with HIV.

The Global Criminalisation Scan

While there have been no prosecutions of HIV transmission thus far in Kenya, the Global Criminalisation Scan Report found that currently the deliberate transmission of HIV is a criminal offense in Kenya punishable under both the Sexual Offences Act (2006) and section 24 of the HIV and AIDS Prevention and Control Act (2006). The wording of these sections are problematic in a number of ways 1) they could be interpreted as criminalising pregnancy or breastfeeding for HIV-positive women, 2) if a person has not yet disclosed their status to their sexual contacts/

partner, section 24 appears to give their healthcare providers the right to disclose the person's HIV status at their own discretion.

Section 26 is worse: It mandates a term of imprisonment of 15 years to life for any person living with HIV who does anything or permits anything to be done (presumably, this includes a woman submitting to sex even if it is against her will) that leads to transmission of HIV or any other sexually transmitted disease, even if the individual is unaware of their HIV-positive status. The bill suggests that a blood sample can be taken for a blood test against the person's will, and if it tests HIV-positive, can be used to as evidence that the person was HIV-positive when the 'act' occurred. However, a test after the fact can never determine which party was HIV-positive first and presumes guilt rather than innocence.

Clearly, enforcement of these bills would lead to the imprisonment of a large proportion of the population of people living with HIV for 15 years to life. They add to the stigma faced by people living with HIV and could scare away PLHIV and pregnant women from accessing needed health services. Similarly, in its conclusion the report notes that other laws in the country, such as the penal code criminalising sex between men, could interfere with HIV prevention services targeting MSM and should be reviewed.

All of these factors limit the potential contribution of HIV-positive individuals in the fight against HIV— in their own lives and in their communities. Taken together, these issues present significant barriers to universal access: potentially reducing the uptake of HIV counselling and testing, as well as access to and uptake of support, care and treatment and prevention services.

Positive Health, Dignity and Prevention

The PHDP framework, emphasising the health and rights of people living with HIV (PLHIV), evolved partly as a response to “Positive Prevention” an earlier attempt by public health officials and prevention specialists to target interventions at HIV-positive people to reduce the risk of onward transmission of HIV. But many people living with HIV felt ‘Positive Prevention’ placed the burden for HIV prevention almost entirely upon those who had tested HIV-positive — as if they were solely responsible for HIV transmission. PLHIV were being treated as a source of infection to be contained, rather than as human beings.

“We held an international technical consultation in Tunisia in April 2009, where people brought examples from various regions, of the kind of messaging that is in their country around Positive Prevention”, said Georgina Caswell of GNP+. “Messages like: ‘PLHIV need to be careful’ or ‘PLHIV should not have sex’.” Such messaging led recently diagnosed people living with HIV to despair, believing they would be unable to be sexually intimate with their partners, their relationships might be at an end, or that they could never conceive children with their HIV-negative partners. In more than one health facility in Africa, the fear of HIV transmission has been taken to extremes: some pregnant women living with HIV have been coerced to terminate their pregnancies— even though higher effective interventions to prevent vertical transmission exist to protect most infants. In other cases, women living with HIV have been sterilised, sometimes without their knowledge.

These human rights violations are in no way associated with Positive Prevention programmes, which were rolled out partly in response to data from some of the more mature HIV epidemics in Africa showing that most of the new HIV infections in countries such as Kenya and Uganda were now occurring among stable partnerships (as opposed to casual partners) when one partner was HIV-positive (serodiscordant couples). In response to the new epidemiological data, with support from PEPFAR and other donors, Positive Prevention programmes were quickly scaled up by international NGOs in a number of countries.

Unfortunately PLHIV were not really engaged in the inception of these programmes. As noted above, many felt that the subtext of the Positive Prevention message was that PLHIV have to be prevented from spreading HIV — as though people knew their HIV status were most to blame for the continued high incidence of HIV in most countries. At roughly the same time, another US funded endeavour made the situation even worse for people living with HIV by introducing a “model” HIV-specific criminal law, a legislative template that has now been used by at least 27 countries to draft laws criminalising HIV transmission. The laws vary slightly from country to country. For instance, in Benin, it is now illegal to fail to disclose the result to one’s partner within six weeks of testing HIV-positive. Given the risks of gender-based violence if they should disclose their HIV-positive status to their partner, women living with HIV may be at greater risk of running afoul of this law.

These laws are unlikely to have an effect on HIV transmission — since it is generally HIV-positive people who are unaware of their status who are most likely to transmit the virus. Nevertheless, people who know they are living with HIV are increasingly being subjected to arrest and incarceration in countries all over the globe. This could prove counter-productive to HIV prevention efforts because it could discourage people from getting tested for HIV and receiving care and treatment. As Frederica Stines, Africa programme officer at the International Women’s Health Coalition was quoted as saying in one news story: “Who wants to know their status if they could be arrested?”

Many people living with HIV, who have experienced HIV-related stigma and discrimination first hand, fervently want to avoid passing on HIV— and should be given the information they need to protect their loved ones and have access to the full range of effective HIV prevention tools. PLHIV could become leaders in HIV-prevention efforts,

but they're less likely to be effectively engaged by prevention programmes that stigmatise them or treat them as irresponsible and reckless.

At the 2009 technical consultation in Tunisia, PLHIV advocates demanded an end to demeaning treatment, and announced that one of the first things that prevention programmes had to do was stop pinning the entire responsibility for HIV prevention upon PLHIV. Rather, they should emphasise that HIV prevention is a shared responsibility. In other words, HIV-negative individuals have the responsibility to take precautions to protect themselves as well — it is not solely the role of the person living with HIV. In fact, it is in an HIV-negative person's interest to practice HIV prevention consistently since their partner may be unaware of his or her HIV status.

People who are unaware that they are HIV-positive may be more likely to practice high risk behaviours, so the HIV advocates at the technical consultation called for HIV testing and counselling services must be universally available and easily accessible so people so that people have up-to-date knowledge of their HIV status.

However, the advocates noted that prevention campaigns with HIV-positive people would miss their mark, where there is little motivation to get tested for HIV. In other words, people will lack an incentive to test if there is no access to care and treatment needed to preserve one's health, or if it is impossible to disclose one's status to one's partner or to live openly with HIV because of stigma and discrimination, or repressive legal environments. Other people may not wish to get tested if it means that they could no longer exercise their human sexual and reproductive rights, such as having children.

The PLHIV advocates called for a new framework 'Positive Health, Dignity and Prevention' to be drafted with a more holistic approach that prioritises the health, wellbeing, and meaningful engagement PLHIV — if these can be secured, prevention interventions would be much more likely to be effective.

Positive Health, Dignity and Prevention argues that, if you improve and if you maintain the dignity of the person living with HIV, and if you support the individual living with HIV around their broad health needs, this will result in a range of benefits including a reduction in the likelihood of new infections.

More recently, GNP+ and its partners have released the ***Positive Health, Dignity And Prevention: A Policy Framework***, which sets forth the following the strategies guiding principles and values:

We are more than patients

People living with HIV are leaders in the design, programming, implementation, research, monitoring and evaluation of all programmes and policies affecting us.

We will not be treated as vectors of transmission

A human rights approach is the foundation of Positive Health, Dignity and Prevention

We are all responsible for HIV prevention

Preventing new HIV infections is the shared responsibility of everyone irrespective of HIV status.

We have needs and desires to be met

Sexual and reproductive health and rights must be recognised and exercised by everyone regardless of HIV status.

Values

Positive Health, Dignity and Prevention can only be achieved through the following points:

- A supportive and protective legal and policy environment that aims for a world free of HIV-related stigma and discrimination.
- A focus on improving and maintaining the health and well-being of people living with HIV, which, in turn, contributes to the health and well-being of their partners, families and communities.

- The promotion of holistic health and wellness, including universal, equitable access to voluntary HIV counselling, confidential testing, care and support and timely access to voluntary treatment and monitoring.
- Addressing a range of factors that undermine health and dignity, including: poverty and food insecurity; lack of mental and psychosocial support; lack of educational opportunity; social exclusion; gender inequality; and stigma and discrimination based on HIV-positive status, behaviours such as injecting drug use, sex work and/or sex between men, and identities such as being lesbian, gay, bisexual, transgender or intersex.
- Responding to the needs of key populations, including the particular and specific needs of [young people and women – not key populations in the same way as marginalised populations actively persecuted, criminalised and driven away from prevention services by society and national governments], and through respectful programmes tailored to specific contexts and the diversity among people living with HIV.

The framework sets out 8 general programmatic components of PHDP, including Empowerment, Gender Equality, Health Promotion and Access, Human Rights, Preventing New Infections, Sexual and Reproductive Health Rights, Social and Economic Support and Measuring Impact. It also describes some of the programmatic elements that might be involved, though these could differ from setting to setting.

I. EMPOWERMENT

- Meaningful involvement of people living with HIV
 - Positive leadership
 - Participation in policy dialogue and advocacy
 - Mentoring of future leaders including women and young people living with HIV
 - Peer support groups
- Education and literacy
 - Treatment
 - Sexual health and comprehensive sexuality
 - Prevention of transmission
 - Reproductive health
 - Family planning
 - Legal and rights
 - Health education for living well (improving nutrition, ceasing smoking, limiting alcohol and drug use, increasing exercise), which helps provide information on health options
 - Building of self-esteem and confidence
 - Age-appropriate and HIV-specific sex and relationships education for children and adolescents born with HIV.
- Capacity building for organizations and networks of people living with HIV
 - Resources for networks and associations of people living with HIV
 - Social mobilisation and community engagement
 - Facilitation of networking opportunities
 - Linking to other social justice and development movements

II. GENDER EQUALITY

- Gender-based violence prevention and management
 - Health-provider training on sexuality, gender, stigma, discrimination and gender-based violence
 - Legal reform and enforcement of laws and mechanisms protecting people from gender-based violence

- Constructive engagement of men in reproductive and sexual health
- Appropriate health services for women living with HIV, including, but not limited to, prevention of vertical transmission of HIV
- Legal advocacy and activism for women's rights
 - Networking opportunities
- Legal advocacy and activism for rights for men who have sex with men, and for lesbian, gay, bisexual, transgender, and intersex people
 - Networking opportunities
- Economic empowerment of women
- Education
- Support for care-giving
- Social empowerment including equality in decision-making and negotiating skills

III. HEALTH PROMOTION AND ACCESS

- Knowledge of HIV status under conditions of informed consent, confidentiality and good counselling
 - Community-based voluntary counselling and testing
 - Provider-initiated counselling and testing
- Treatment and care access, availability, sustainability, and quality assurance
 - Clinical monitoring
 - Availability and access of timely and appropriate antiretroviral therapy
 - Antiretroviral therapy adherence support
 - Prevention of disease progression and further infections
 - Prophylaxis for tuberculosis (TB) and other opportunistic infections
 - Diagnosis and treatment for TB and other opportunistic infections
 - Diagnosis and treatment for Hepatitis C and other co-infections
 - Research and better understanding about the long-term effects of antiretroviral therapy and HIV, including youth who acquired HIV perinatally
 - Palliative care
 - Facilitated referral systems
- Psychosocial well-being services access, availability, sustainability, and quality assurance
 - Mental and emotional health services
 - Counselling services and support groups

IV. HUMAN RIGHTS

- Confidentiality of HIV-positive status
- Conditions for safe, voluntary, and beneficial disclosure
- Respect for individual autonomy
 - Choosing when, and if, to test, disclose, and/or initiate antiretroviral therapy
- Establishment of an enabling environment, including protective laws
 - Stigma and discrimination reduction
 - Support for advocacy and activism leading to legal and policy reform and implementation
 - A focus on shared responsibility for preventing new HIV infections, including removal of HIV-specific criminal laws

V. PREVENTING NEW INFECTIONS

- Access and availability of tools and technologies that help prevent sexual HIV transmission
 - Male and female condoms and water-based lubricants
 - Male circumcision
 - Antiretroviral therapy
 - Post-exposure prophylaxis
 - New prevention technologies, such as pre-exposure prophylaxis and microbicides, as and when they become available

- Access and availability of services that help prevent vertical transmission
 - Primary prevention of HIV infection among women of childbearing age
 - Preventing unintended pregnancies among women living with HIV
 - Preventing HIV transmission from a woman living with HIV to her infant, including breast-feeding information and support
 - Providing appropriate treatment, care and support to mothers living with HIV and their children and families.

- Access to evidence-informed harm reduction for people who use drugs, including opiate substitution therapy

- Serodiscordant couples counselling (including partner and couples testing)

- Prevention, screening and treatment of sexually transmitted infections, including viral hepatitis
 - Human papillomavirus vaccination
 - Hepatitis A and hepatitis B vaccination

VI. SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

- Sexual health and well-being
 - Age-appropriate, comprehensive sexuality education, including a focus on the specific needs of adolescents born with HIV
 - Prevention and treatment of sexually transmitted infections, including viral hepatitis
 - Counselling and support for a satisfying sex life, including but not limited to improving libido, and treating sexual dysfunction

- Reproductive health
 - Maternal health
 - Family planning, including infertility and contraceptive services
 - Cervical, breast and other related cancer screening and management
 - Access to appropriate, safe and non-coerced termination services

- Sexual and reproductive health and rights advocacy and funding

VII. SOCIAL AND ECONOMIC SUPPORT

- Food and water security
- Social and economic support for caregivers
- Access to financial services
 - Support of productive linkages, including cooperatives

- Employment of people living with HIV

- Further education and retraining opportunities for adults with HIV
 - Access to full education and employment opportunities for young people living with HIV
- Health and social protection for children and adolescents living with HIV

VIII. MEASURING IMPACT

- Develop monitoring and evaluation systems to measure impact and progress towards Positive Health, Dignity and Prevention



Notes



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