COUNTRY PROFILE: KENYA

From Political Commitments to Accountable Investments in Community Leadership and Societal Enablers for Kenya.

Table of Contents

List of Tables

List of Figures

Abbreviations

CBO	Community Based Organization
CEDAW	Committee on the Elimination of Discrimination against Women
CLM	Community Led Monitoring
CLSE	Community Leadership and Societal Enablers
D-GGHE	Domestic general government health expenditure
FSW	Female Sex Workers
GDP	Gross Domestic Product
GF	The Global Fund
GPC	Global HIV Prevention Coalition
HCI	Human Capital Index
HDI	Human Development Index
IMR	Infant Mortality Rate
LARCOD	Lake Region Community Development Initiative (LARCOD)
MSM	Men who Have Sex with Men
NACC	National AIDS Control Council
NASCOP	National AIDS and STI Control Program
NEPHAK	National Empowerment Network of People Living With HIV/AIDS in Kenya
NGO	Non-Governmental Organization
NSDCC	National Syndemic Diseases Control Council
PLHIV	People living with HIV
PWID	People who inject drugs
PWUD	People who use drugs
RSSH	Resilient and Sustainable Systems for Health
SE	Societal Enablers
TB	Tuberculosis
U5MR	Under Five Mortality Rate
UHC	Universal Health Coverage
UNESCO	United Nations Educational, Scientific and Cultural Organization
WOFAK	Women Fighting AIDS in Kenya

1. INTRODUCTION

1.1. Background

From the beginning of the HIV response, communities of beneficiaries have provided feedback on the quality, effectiveness and equitable access to HIV programs and services. However, such feedback has not been effective owing to the lack of systematic mechanisms for gathering, collating, sharing and using the community-based data.

As the world advances towards Universal Health Coverage (UHC) priority groups such communities of people who use drugs (PWUD), sex workers, lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) people and people living with HIV are often poorly served due to exclusion, either systemically or through stigma and discrimination faced at health programmes and services. To identify inequities and define priority rights-based actions to address such gaps, leadership is required. As a result, there is growing support for communities of people living with and affected by HIV to collect and use their data to improve their health and broader societal situations and to hold decision-makers and service providers accountable for reaching their HIV commitments.

Community Leadership is an accountability mechanism for HIV responses at different levels, led and implemented by local community-led organizations of people living with HIV, networks of key populations, other affected groups or other community entities[1]. CLM data is collected to complement local, national and international monitoring and, provides key information to fill critical gaps in the decision-making process leading to evidence-informed actions to improve policy, investments and service delivery.

> ***"Response gaps in pandemics, whether HIV or COVID-19, lie along the fault lines of inequality."***
>
> António Guterres
>
> United Nations Secretary-General

While Community Leadership has been recommended by a broad range of global stakeholders, it has not been implemented at scale due to many reasons, including: lack of capacity among community actors; inadequate resourcing; lack of coordination among stakeholders and lack of consensus on critical indicators for Community Leadership. To catalyse the implementation and scale up of Community Leadership, it is necessary to develop a roadmap to unify stakeholder efforts, guide investments, address capacity gaps and build consensus on indicators and targets to be monitored by communities.

Given the insufficient documentation of the status of Community Leadership and Societal Enabler Programming in Kenya, this Country Profile bears significant potential in informing action planning and acts as a reliable reference guide for capacity building and other strategic investments.

1.2. Objectives

Main Objective

- Collect, analyze data in order to develop a country profile, combined with a civil society advocacy roadmap "From Political Commitments to Accountable Investments in Community Leadership and Societal Enablers" for Kenya.

Specific Objectives

[1] Establishing community-led monitoring of HIV services: Principles and process: UNAIDS Joint Programme, 2021

- Conduct comprehensive desk review of published and/or grey sources and interviews with key national and international stakeholders.
- Compile Country Profile on CLM and Societal Enabler Programming in Kenya.
- Facilitate stakeholder consultative sessions in order to:
    - Validate the country profile.
    - Raise awareness of national stakeholders on the value of community leadership, community systems and programs enabling gender equality, non-discrimination and decriminalization (i.e. societal enablers) for strengthening health systems and reaching the Universal Health Coverage (UHC);
    - Develop a country-specific civil society advocacy roadmap to advocate for investments in and scale up of community-led monitoring of SRHR and HIV services, of human rights violations and funding for community-led responses.

2. METHODOLOGY

2.1. Inception

The consultancy commenced with a virtual inception meeting between the client representatives from WACI Health, and the consultant. The meeting sought to ensure alignment on the scope and terms of reference, the timelines and implementations arrangements.

2.2. Data Collection

Desk Review

The consultancy team conducted an in-depth desk review of available literature on CLM and Societal Enabler programming at national, regional and global level, including country reports from the Ministry of Health and partners like PEPFAR, Global Fund, UNAIDS, HENNET, Health Gap among others.

Electronic Surveys

The WACI team reviewed and contextualized the data collection tools to ensure alignment and fit to the Kenyan context. The refined tool was then administered to key respondents via electronic surveys. (Annex 1)

The key respondents were purposively selected by the project team based on their knowledge and level of engagement in Community Leadership, Key Population and Societal Enabler Programming in Kenya. Nine respondents filled out the electronic survey (Annex 2)[2].

The stakeholder insights complemented findings drawn from the in-depth desk reviews of available government, regional and global resources on Societal Enablers and Community Led Monitoring.

Group Convenings

Additional insights were drawn directly from the consultative meetings held on 6th September and 12th September 2023 with more than 50 Key Populations and Community Representatives respectively (Annex 2).

Key Populations Consultation

[2] *Sample size in qualitative interview studies: guided by information power.* **Malterud, K, Siersma, V.D and A.D, Guassora.** 13, Copenhagen : Sage Journals, 27 November 2015, Qualitative Health Research, Vol. 26, pp. 1753-1760.

WACI Health facilitated the convening of Key Populations to deliberate on the country investments, processes, and accountability systems for Community Leadership and Societal Enabler programming.

2.3. Drafting

The desk review findings and insights from the electronic surveys and consultative meetings were thematically analysed (qualitative data) and summarized via measures of dispersal (quantitative data) and subsequently tailored into a draft country profile.

2.4. Consultation Meetings

The consultative meetings were held among Key Populations (6th September), and among Health Sector NGOs (12th September, 2023) prior to the 2023 UNGA High Level Meeting on Health in New York.

Attendant feedback and input from the consultative meetings were included in the Country profile.

3. COUNTRY PROFILE

3.1. Health System Context

3.1.1. Demographics

The population of Kenya has progressively increased from an estimated 47M in 2017 to slightly above 53M in 2022. The life expectancy at birth fluctuated between 61.4 years to 62.9 years during the same period as shown in figure 1. Disparities still exist based on geographical location and gender. Life expectancy is higher among females and among urban populations.

The latest available Human Capital Index[3] for Kenya in 2020 was 0.55 as in figure 1. This means that a child born in Kenya in 2020 could expect to be 55% as productive when they grow up as they could be if they enjoyed complete education and full health. While this is higher than the Sub-Sahara Africa average (0.4), it was slightly lower than the global average of 0.57.

Kenya latest Human Development Index[4] (HDI) from 2021 was 0.6. This means that the population in 2021 had moderate life expectancy, literacy rates, and per capita incomes. While this HDI was higher than the Sub Sahara Africa average of 0.55, it was significantly lower than the global average of 0.73.

[3] The Human Capital Index (HCI) measures which countries are best in mobilizing their human capital, the economic and professional potential of their citizens. The index measures how much capital each country loses through lack of education and health.

[4] The Human Development Index (HDI) is a summary measure of average achievement in key dimensions of human development: a long and healthy life, being knowledgeable and having a decent standard of living.

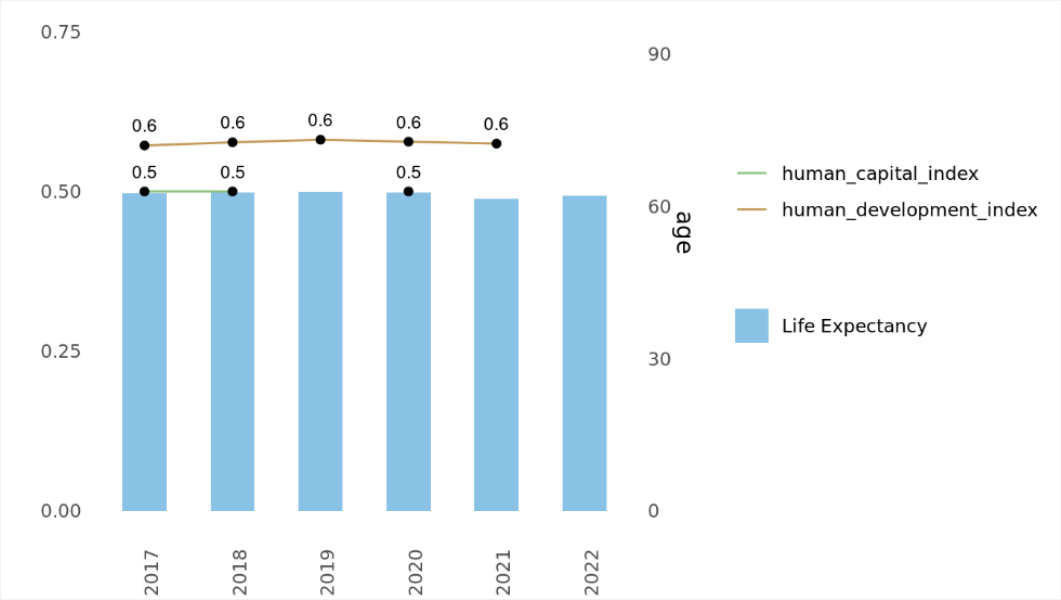


Figure 1: Population Productivity Potential

Source: UN, World Bank and Analysis by consultant

The selected health outcomes (Infant Mortality and Under Five Mortality Rates) have been steadily improving over the same period of time. Infant Mortality Rate dropped from 31.6 per 1000 live births in 2017 to 28 per 1000 live births in 2021. Under Five Mortality Rate dropped from 42.4 per 1000 live births in 2017 to 37.2 per 1000 live births in 2021. (Figure 2)

The UHC Service Coverage Index[5] has on average been at 56% compared to the Africa Average of 48% and the Global Average of 68% in 2021. This means that 56% of the population have access to essential health services including reproductive, maternal, newborn and child health, infectious diseases, and non-communicable disease services.

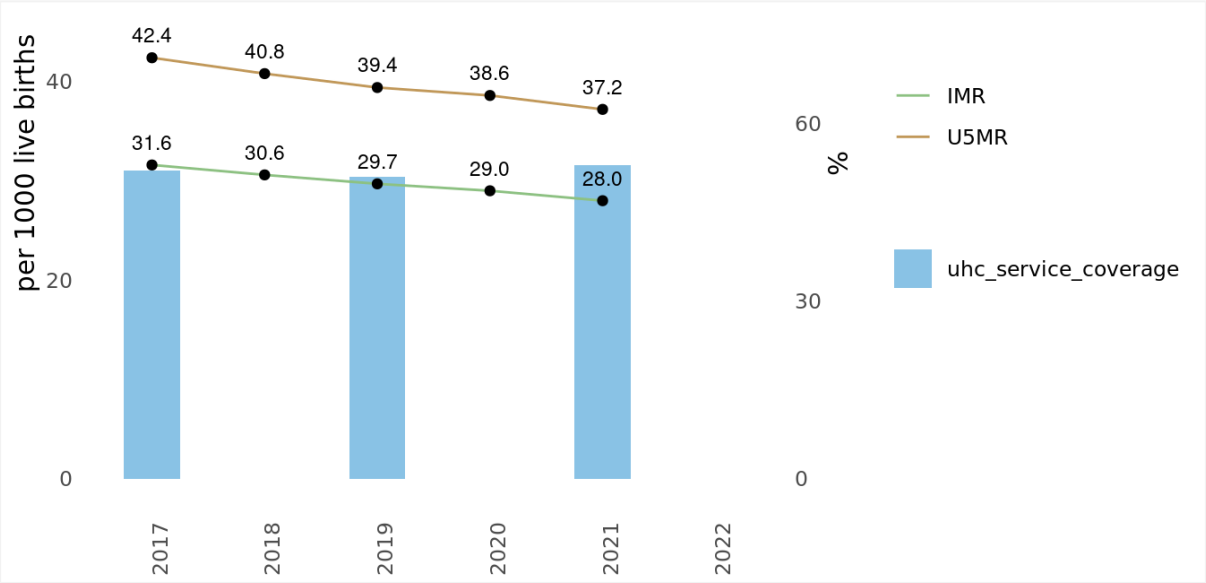


Figure 2: Selected Health System Performance Indicators in Kenya

[5] Coverage index for essential health services (based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, noncommunicable diseases and service capacity and access). It is presented on a scale of 0 to 100.

Highlight

Given the moderate HDI and HCI scores, the government needs to increase investments targeted at addressing the Social Determinants of Health and alleviating the drivers of inequality.

3.1.2. Health Financing

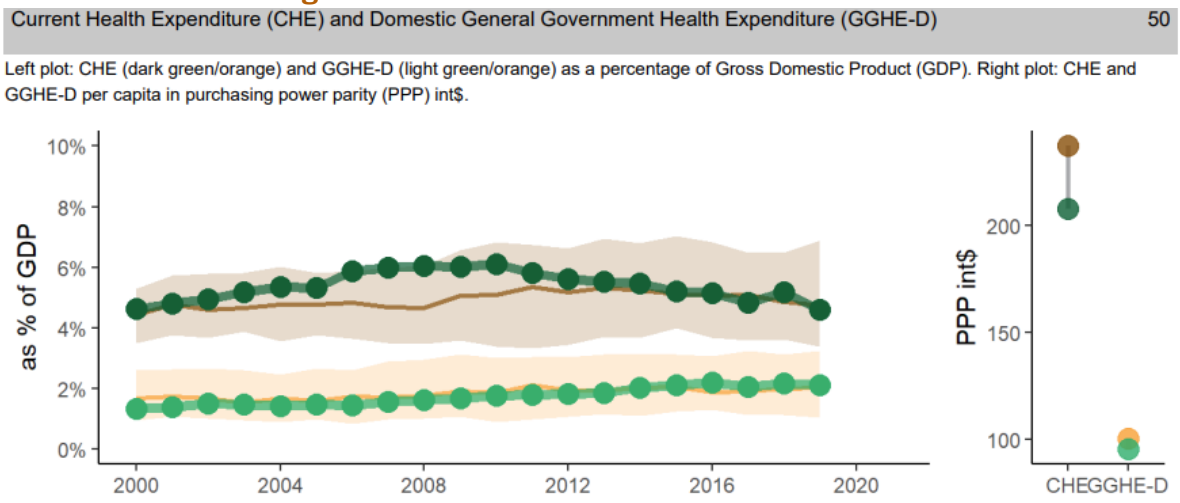


Figure 3: Health Financing Trends in Kenya

Source: Global Fund

The Current Health Expenditure (from all sources) in Kenya has been fluctuating between 4% and 6% of the Gross Domestic Product (GDP) over the period between 2000 and 2019 as in Figure 3 above. Notably, the government financing of health from domestic sources has consistently been below 3% of the GDP against the recommended 5% threshold.

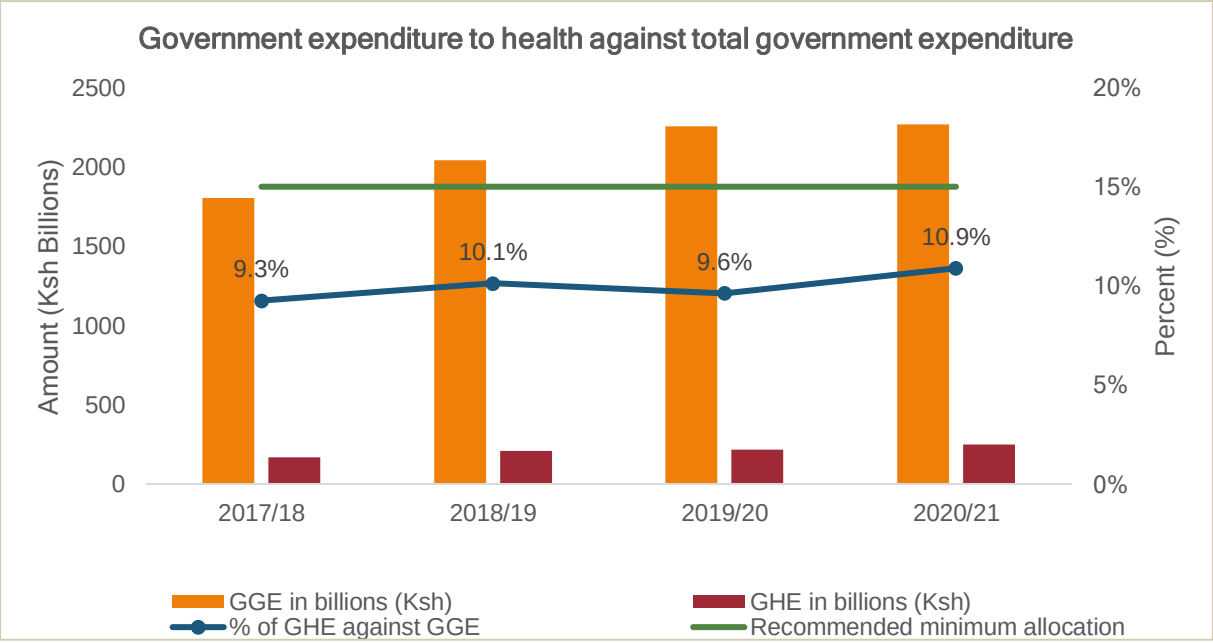


Figure 4: Government Expenditures on Health

Source: National Health Accounts

Further, the government expenditures to health have consistently been below the Abuja threshold of 15%, ranging between 9.3% and 10.9% of the total government expenditures between 2017 and 2021 as shown in figure 4.

Highlight

The ongoing donor transitions necessitate urgent increments in government financing of health to at least 5% of GDP and 15% of the national budgets so as to ensure continuity of care.

3.1.3. HIV/AIDS

HIV Treatment and Prevention

Currently in Kenya, it is estimated that 1.37 million people are living with HIV, 1.29 million are on ART and 89% of these are virally suppressed. Of those living with HIV, 67,871 are children. As of 2021, 92% knew their status, and 78% were on treatment as shown in figure 6.

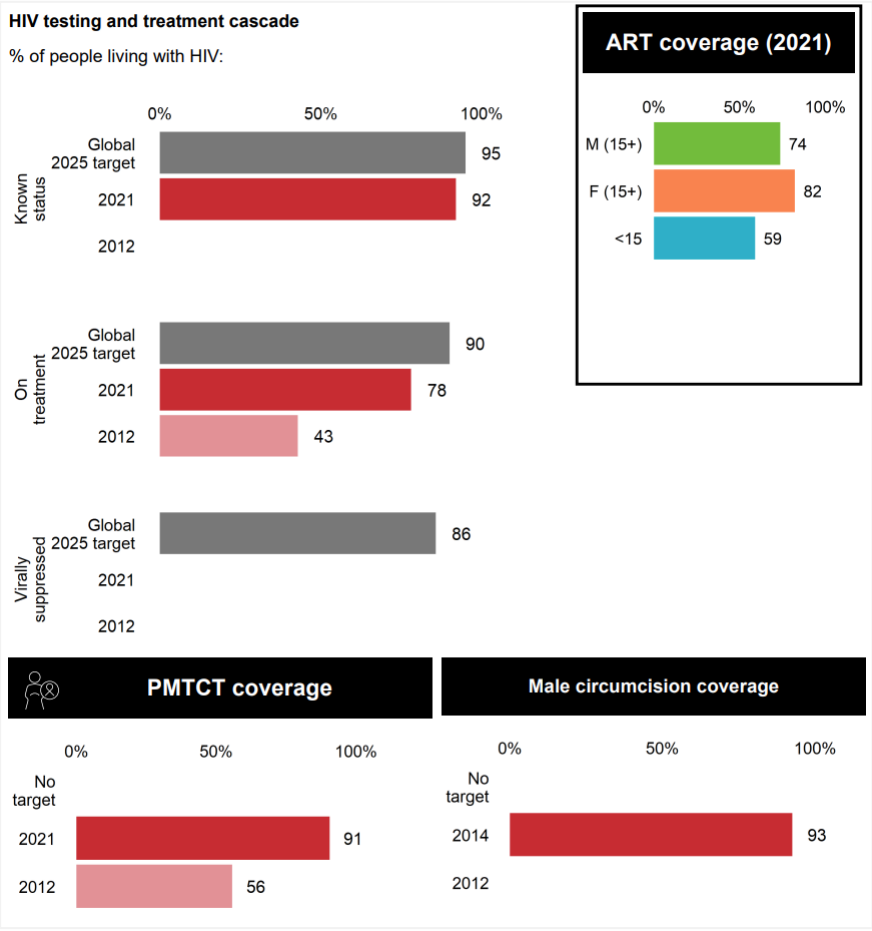


Figure 5: HIV testing and treatment cascade in Kenya

Source: Global Fund

The coverage was highest among females aged 15 years and above (82%), followed by males aged above 15 years (74%) and lowest among children below 15 years of age (59%). The 2023 estimates show that 57,368 (84.6%) children are on ART and 74% of these are virally suppressed.

Figure 6: HIV Infections and Deaths

Source: Global Fund

New HIV infections have reduced by 52.7%, that is from 47,000 in 2015 to 22,155 PLHIV. The decline over the last two decades has been significant, estimated at 73% as in figure 7.

Further in the same period, AIDS-related deaths have reduced by 47.2% that is from 35,000 to 18,474 PLHIV. Over the last two decades, the reduction in AIDS related deaths is estimated at 49% as in figure 7 above. These are tremendous gains that need to be maintained and improved upon to attain epidemic control.

Highlight

The gains made in HIV treatment and care over the last two decades are significant and worth sustaining in spite of the donor transitions. Understanding and documenting contextual needs and realities thus necessitate meaningful community leadership within an enabling environment.

HIV Financing

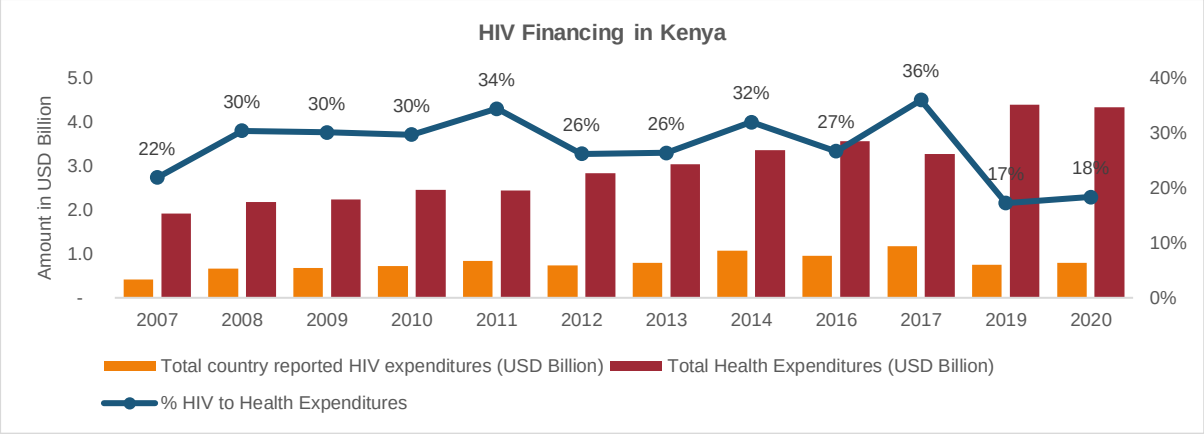


Figure 7: HIV Financing Trends in Kenya

HIV expenditures accounted for between 17% and 36% of the Total Health Expenditures in Kenya between 2007 and 2020 as shown in figure 8. Though fluctuating, the general trend shows declining prioritization of HIV over the years; a concerning trend given the ongoing donor financing transitions.

HIV Funding Sources

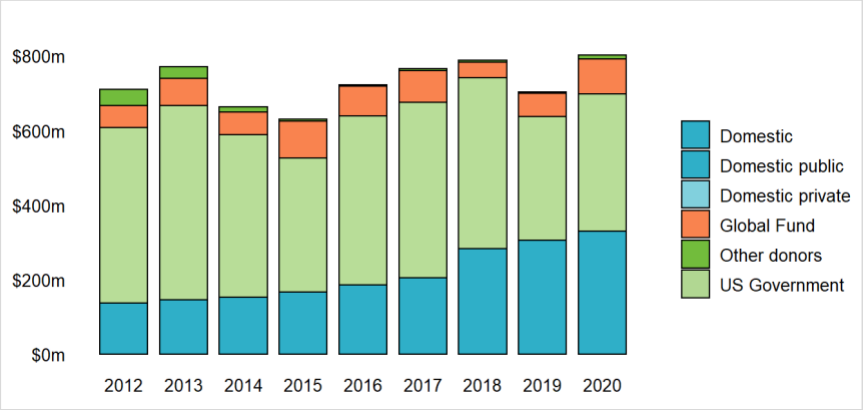
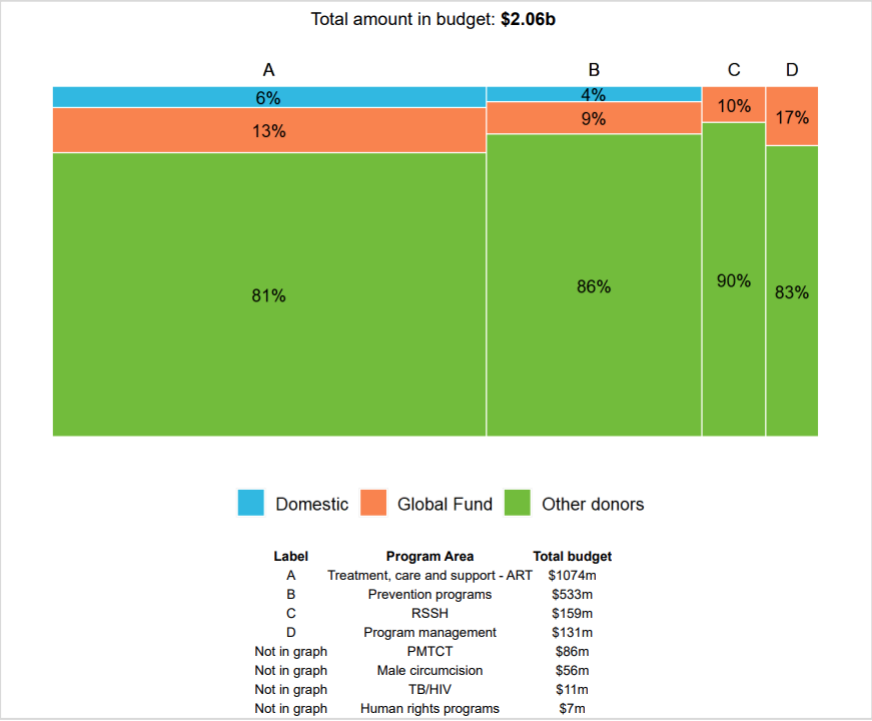


Figure 8: Historical investments for HIV in by funding source (2012-2020)

The cost of all HIV services in the public sector is primarily borne by the government and externally generated resources. The government funding has been progressively increasing but still accounts for less than 50% of all HIV financing as shown in figure 9. UNAIDS 2022 data shows that the Government contributes 40.3%, while PEPFAR and Global funds cater for 45.3% of the service provision financial needs.



Label	Program Area	Total budget
A	Treatment, care and support - ART	$1074m
B	Prevention programs	$533m
C	RSSH	$159m
D	Program management	$131m
Not in graph	PMTCT	$86m
Not in graph	Male circumcision	$56m
Not in graph	TB/HIV	$11m
Not in graph	Human rights programs	$7m

Figure 9: Investments by Intervention (2018-2020)

Source: Global Fund

Notably, funding for community led monitoring has been predominantly donor funded as shown in figure 10. PEPFAR and Global funds have been the main funders (90% and 10% respectively). Significant Societal enabler funding e.g., for human rights programs between 2018 and 2020 has been from donors.

Among selected Key populations, government financing for Sex Workers has progressively increased, but remains limited for MSM and PWID programming as in figure 11.

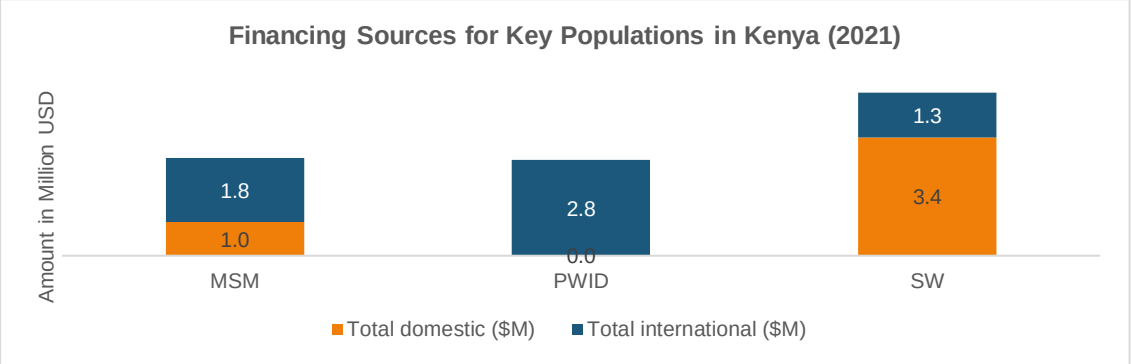


Figure 10: Financing for Key Populations

Highlight

The high donor dependence in financing of HIV, CLM and Societal Enabler programming in Kenya threatens sustainability of interventions and gains made thus far, particularly with the ongoing donor financing transitions.

There is an urgent need for progressive increments in government investments in HIV, CLM and Societal Enabler programming to ensure sustainability and quality of care.

3.2. Community Leadership

3.2.1. Legal and Policy Environment

The legal and policy environment for Community Leadership activities in Kenya draws from both local instruments and global instruments that have been ratified or adopted by the government by virtue of articles 2(5) and (6) of the Constitution of Kenya, 2010.

a. <u>Local Laws, Policies and Guidelines</u>

Kenya's supreme law of the land, the Constitution of Kenya, 2010, provides the anchor for all matters CLM. Article 43 of the Constitution provides that every person has the right to the highest attainable standard of health which includes health services.

The Bill of Rights in Chapter 4 clearly spells out the need for equality, outlaws' discrimination, and encourages inclusiveness and public participation in matters of public interest.

Further, through Schedule 4, the Constitution of Kenya further provides for the roles of the National and County level governments in ensuring access to healthcare, including sexual and reproductive health.

The Health Act No. 21 of 2017 was enacted to operationalize the constitutional right to health by clarifying the nature of rights and duties relating to the right to health as well as the roles of the national and county governments, and state agencies on health.

Additionally, Kenya has other operational and strategic policy documents that support CLM. These include the Kenya AIDS Strategic Framework II (2020/21-2024/25), The 2021/2022-2026/2027 National AIDS Control Council (NACC) strategic plan, the NASCOP Strategic Plan (2023-2028), and The HIV Prevention Acceleration Plan 2023–2030, Kenya HIV Prevention

Revolution Road Map: Count Down to 2030. The above documents bring to core the country's prioritization of Community Leadership as a key component of HIV/AIDS programming.

These documents also contextualize the HIV Prevention 2025 Road Map (Figure 12) developed by the Global HIV Prevention Coalition (GPC) of 28 priority countries to which Kenya is a member state.

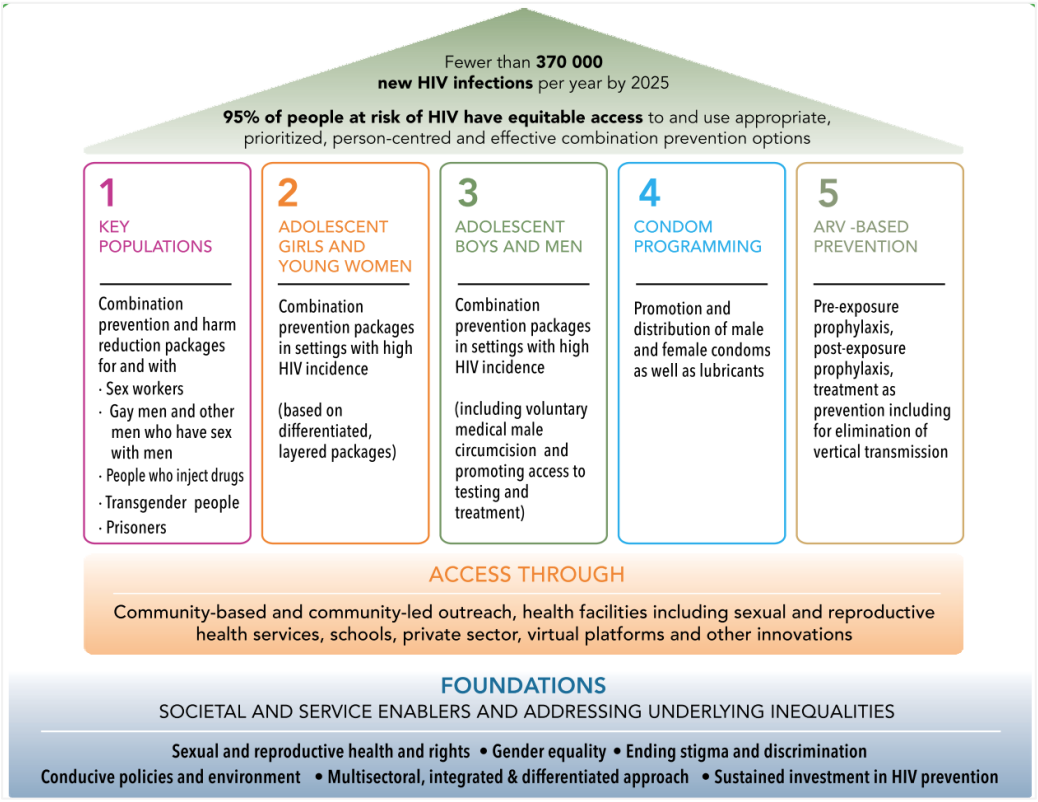


Figure 11: The five HIV prevention pillars

Source: The HIV Prevention Acceleration Plan 2023–2030

The roadmap prioritizes Societal Enablers as foundational, and Community Systems as critical access pathways for HIV Prevention.

The country also has enabling laws and regulations that provide the optimal environment for establishment, registration, and operationalization of CBOs, enabling social contracting. Additionally, the Data Protection Act of 2019 gives effect to articles 31(c) and (d) of the constitution, hence enshrining privacy as a constitutional right.

International Laws, Policies and Guidelines

The following represent international instruments that could be used to hold Kenya accountable on health and human rights:

a) The UN Human Rights Committee through procedure 1503;
b) The Special Rapporteurs for violations of specific human rights;
c) CEDAW for women's rights violations;
d) The UNESCO procedure for human rights violations in UNESCO's fields of mandate
e) Kenya is also a member of the African Union and its citizens and NGOs may file complaints to the African Commission on Human and Peoples' Rights.

The UNAIDS guidelines for establishing and conducting CLM is a key guiding document of the CLM process. It is bolstered by other documents like the Global Fund's guidance on including CLM in its funding requests as well as operational guidelines by IPTC and EPIC.

PEPFAR through its current strategic plan (5by3 Strategy), lays emphasis on Community Leadership as a key enabler towards elimination of HIV as a public health threat by 2030 (Figure 13).

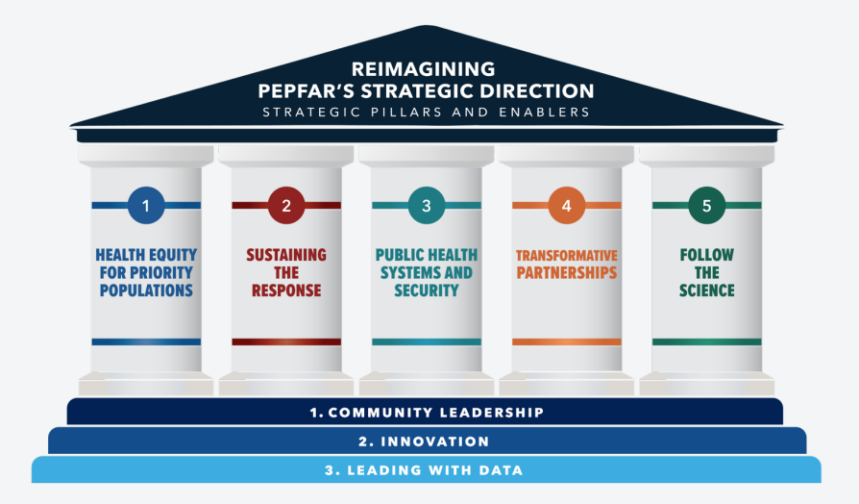


Figure 12: PEPFAR 5 by 3 Strategy

Additionally, through its annual Country Operational Plan (COP) Guidance, PEPFAR has helped elevate Community Leadership as a priority at country and global level from COP 21 to the current COP 23.

PEPFAR has also facilitated institutionalization of Community Leadership in Kenya through the establishment of a CLM coordinator within the country's PEPFAR Coordination Office as well as establishment of an in-country fund for Community Leadership coordination and activities.

3.2.2. Processes and Structures

In Kenya, processes, and structures for Community Leadership do exist, albeit in nascent phases.

First, Kenya has a well-established and vibrant civil society emboldened by a free democratic space. The country has a multi-sectoral national Community Leadership coordinating mechanism that is responsible for implementation of Community Leadership activities in the country. The coordination is strongly led by civil society and has representation from donors as well government. This includes the GF Kenya Coordinating mechanism that has anchored Community Leadership coordination among its structures.

Additionally, there exists local and international organisations, e.g., AMREF, NEPHAK, WOFAK with long rooted presence and strong relations with communities in the country preceding the Community Leadership era.

PEPFAR, one of the main donors for the HIV program has institutionalized Community Leadership in its office through the establishment of a Community Leadership coordinator within the country's PEPFAR Coordination Office as well as establishment of an in-country fund for CLM.

The publication of the annual People's COP provides an institutionalized platform for responding to PEPFAR's COP guidance at the national levels, highlighting key priorities from the perspectives of recipients of care and their community groups.

3.2.3. Investments

a. PEPFAR

In 2021, PEPFAR granted new awards to Civil Society Organizations (CSOs) and Community-Based Organizations (CBOs) to implement Community Leadership activities within COP21. Three CSOs were funded by COP21 for Community Leadership as follows:

- National Empowerment Network of People Living With HIV/AIDS in Kenya (NEPHAK)
- Lake Region Community Development Initiative (LARCOD)
- Women Fighting AIDS in Kenya (WOFAK)

PEPFAR also had plans in place to secure a fourth partner who would focus on the quality of care and services provided to key, priority, and vulnerable populations.

In the subsequent year (COP22), PEPFAR funded CLM activities in Homabay, Kilifi, Makueni, Mombasa, Nairobi, Nakuru, Narok, Kisumu, Samburu, and Turkana counties. There was a commitment for a fourth award expanding outreach to cover additional counties.

Table 1: PEPFAR Commitments to Kenya

FUNDING CYCLE	PIPELINE	NEW FUNDING	TOTAL BUDGET	OF WHICH COMMUNITY LEADERSHIP
COP 2023 Year 2 (2024) National Budget (USD)	-	-	327,917,500	0*
COP 2023 Year 1 National Budget (USD) (2023)	47,317,192	298,932,808	346,250,000	0*
COP 2022 (USD)	7,583,639	337,416,361	345,000,000	83,129
COP 2021 (USD)	19,735,303	363,203,697	382,939,000	1,200,000

Source: COPs

b) Global Fund

The Global Fund, through allocations to Community Systems Strengthening under the Resilient and Sustainable Systems for Health (RSSH) Module in both the New Funding Model Cycles 2 and 3 funded Community Leadership and Societal Enablers. This accounted for

between 1.5% of the entire NFM2 budgets and 3.5% of the entire NFM3 budgets as shown in Figure 14.

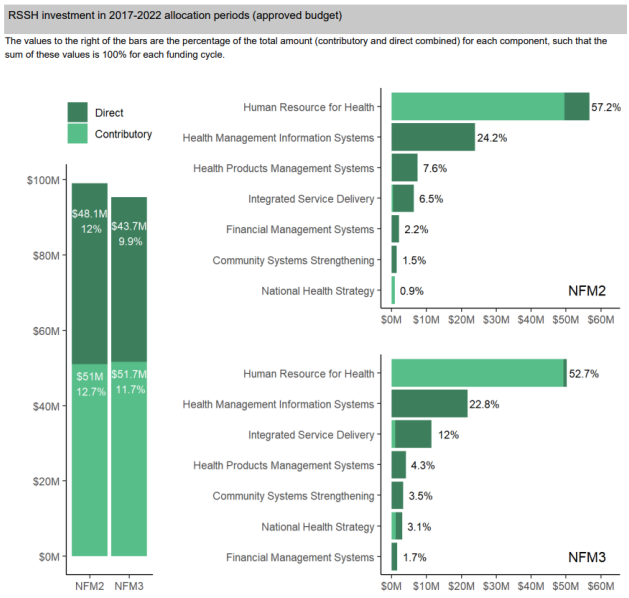


Figure 13: GF RSSH Investments in Kenya - Global Fund

Community Leadership at Community and County Levels through GF Allocations

In the New Funding Model 2 (NFM 2) of the Global Fund grant, through AMREF, Kenya implemented the Community Led Monitoring (CLM) activities in 3 counties (Kwale, Homabay and Vihiga), using Imonitor+[3].

Between 2021 and 2024, the fund has allocated a total of US$441 million in six grants addressing HIV, tuberculosis (TB) and malaria in Kenya[4]. Of this amount, the fund signed 241,385,285 USD for AMREF and 220,875 USD for NEPHAK- two of the Principal Recipients (PRs) that implement CLM in the country.

In the implementation years of 2021 to 2023 AMREF's GF project is implementing CLM using Imonitor+ in 15 counties of Busia, Homa Bay, Kakamega, Kisii, Kisumu, Kitui, Kwale, Migori, Mombasa, Nairobi, Siaya, Taita-Taveta, Turkana, Uasin Gishu & Vihiga. The GF is also funding technical support to Kenya through EANNASSO (East Africa National Networks of AIDS and Health Services Organizations) to develop tools and indicators for CLM.

c) Government Investments

While the bulk of CL and SE funding is from partners, the Government of Kenya has also made some investments in strengthening CLSE programming in the country. The consolidated HIV spending analysis between 2016 and 2020 shows that less than 2% of the annual allocations went to Social Enablers (Figure 15). Further, allocations to social protection and economic support accounted for between 6% and 8% of the annual allocations.

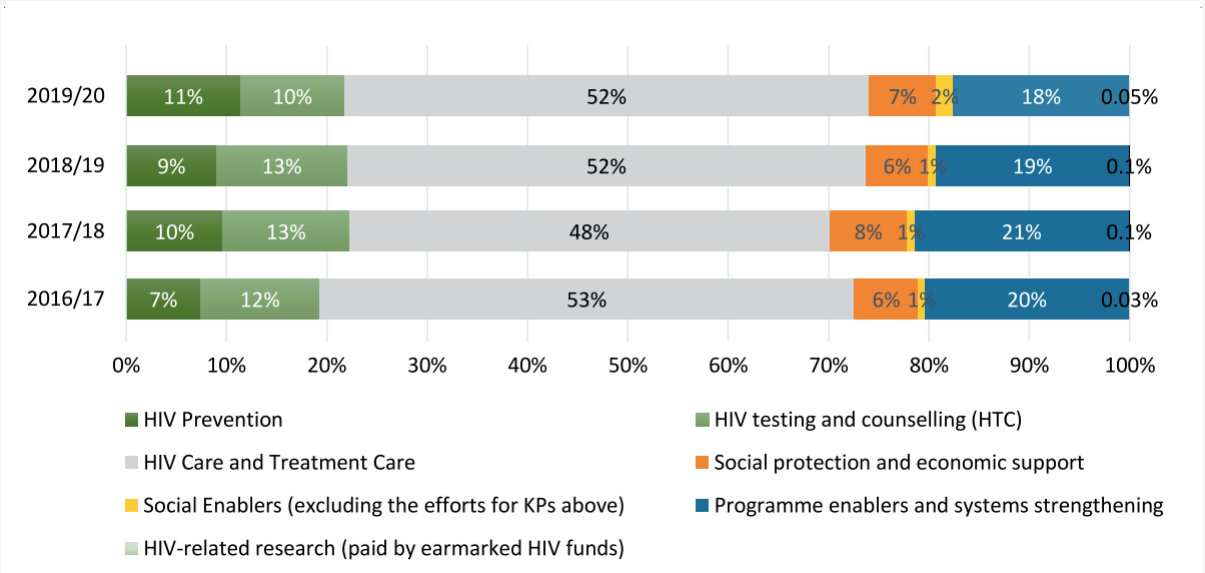


Figure 14: HIV Expenditures by Broad Spending Categories in Kenya

Source: KNASA 2022

The Government of Kenya applied for, and received, human rights matching funds of USD $3.8 million from GF for programs to remove human rights-related barriers to HIV services for the grant period 2018 to 2021. Kenya matched 1:1 from the general allocation.

3.2.4. Barriers

Key themes highlighted around the challenges to Community Leadership Implementation in Kenya include the following:

1. **Funding Constraints:** The primary challenge is the inadequate funding and resource allocation for community monitoring initiatives. Insufficient financial support from government and external donors restricts the resources necessary for training, technology, and community engagement, hindering the scale-up of these initiatives.
2. **Complex Regulatory Frameworks:** Compliance with regulatory frameworks poses a significant barrier to scaling up community monitoring efforts. This includes a lack of clear legal guidelines specific to community monitoring, leading to uncertainty regarding data privacy and ownership. Additionally, complicated rules and slow approval processes may make it difficult for community monitoring to function smoothly.
3. **Limited Supportive Policies and Legal Frameworks:** There is a pressing need for supportive policies and legal frameworks to protect community rights and participation. Legal loopholes in policy implementation, coupled with limited legal support in policy-making and implementation, hinder the legitimacy and effectiveness of community monitoring initiatives, particularly among Key Populations.
4. **Limited Collaboration and Crosstalk:** Collaboration among communities and initiatives is often lacking, resulting in fragmented efforts and inefficiencies. Cross-talk and coordination between different stakeholders are crucial for the success of community monitoring.
5. **Political Will and Commitment:** Limited political goodwill to implement commitments related to community monitoring is a critical barrier. Divided commitment among partners and partiality among key funders and implementers further undermine the effectiveness of these initiatives.

6. **Mentorship and Capacity Building:** There is a need for mentorship and capacity building within Civil Society Organizations (CSOs) and communities involved in monitoring. The limited mentorship hampers the development of effective monitoring strategies.
7. **Territorialism Among CSOs:** Competition and territorialism among existing CSOs impede collaboration and resource sharing, hindering the progress of community monitoring.
8. **Accountability Deficits:** Limited accountability mechanisms among duty bearers make it challenging to enforce the implementation of policies related to community monitoring.
9. **Bureaucracy in existing structures:** Protracted red tape in funding processes, while critical for accountability, further limits timely implementation of community monitoring initiatives.
10. **Stigma and Discrimination:** Stigma and discrimination against communities, including PLHIV and Key Populations, hinder their participation in community monitoring efforts and can skew the collected data.
11. **Information Barriers:** Misinformation, language barriers, and limited use of technology affects data quality and the effectiveness of communication among stakeholders. This is further exacerbated by complex technology, limited training and orientation to the tools in use.
12. **Policy Gaps and Criminalization:** Restrictive or non-existent laws and policies for Community Led Monitoring, particularly concerning Key Populations, limit legal protection and support for community monitoring initiatives.
13. **Limited Visibility and Evidence:** Certain populations, like LBQ communities, may lack visibility and sufficient evidence on their care, further complicating their engagement in community monitoring.
14. **Geographical Limitations:** Geographical constraints may limit the scope and reach of community monitoring initiatives, especially in rural areas.
15. **Continuity and Cascading:** Limited continuity of approaches and a lack of cascading to grassroots levels beyond policy and program levels hinder sustained community monitoring efforts.

3.3. Societal Enablers

3.3.1. Legal and Policy Environment, Processes and Structure

Kenya's legal and policy framework provides a mixed environment that may be deemed as both progressive and retrogressive, with protective and discriminatory components.

a. Protective and Enabling Framework

The Constitution of Kenya, 2010, is a transformative law and elevates equality and non-discrimination as fundamental rights for all. The principle of equality and non-discrimination within the Constitution of Kenya, 2010, is enshrined within Chapter 4, the Bill of Rights;

- Section 21(3): Guarantees protection and fulfilment of the needs of the Vulnerable, including Women
- Section 27(3): Guarantees equal treatment and opportunities
- Section 59(1): Facilitates Gender Mainstreaming and establishes the Kenya National Human Rights and Equality Commission

It is thus the obligation of the state and all its organs (National and County level) to not only respect, but also protect and fulfill the guarantees enshrined within the Bill of Rights.

The existing legal framework further guarantees the following:

- Requirement for both public and private entities to comply with the inclusion principles and gender, among others
- Equality in leadership with 33% as the critical mass preferred for women leadership
- Equality in marriage
- Equality in employment
- Equality in access to education
- All discriminatory customary practices are prohibited
- Matrimonial property is protected
- Women rights to inheritance and to own land
- Equal parental responsibility

The Supportive Legislation within the Kenyan legal framework includes (but not limited to) the following:

- The Kenya Health Act (Act no. 21 of 2017) establishes a unified health system.
- National Gender and Equality Act 2011 which guarantees gender mainstreaming and also establishes the National Gender and Equality Commission (NGEC)
- Marriage Act (No. 4 of 2014)
- Protection Against Domestic Violence Act (No. 21 of 2015)
- Basic Education Act 2013
- Matrimonial Property Act (No. 49 of 2013)
- Micro and Small Enterprises Act (No 55of 2012)
- Employment and Labour Relations Court Act No. 20 of 2011
- The prohibition of female Genital Mutilation Act 2011
- Counter Trafficking in Persons Act 2010
- Sexual offences Act 2006
- Citizenship and Immigration Act, 2011
- Law of Succession Act 2012

b. Discriminatory and Punitive Laws

The following are sample legislative instruments that are deemed discriminatory hence limiting effective CLM and SE programming:

Chapter 63, Section 162, 163, and 165 of Kenya's penal code criminalize consensual same-sex relations with up to 14 years in prison. The High Court rejected a constitutional challenge to the ban in May 2019.

The law takes action on women who live on prostitution. Section 154 of the Penal Code provides that any person who knowingly lives wholly or partly on the earnings of prostitution is guilty of a felony and is liable for punishment.

The Sexual Offences Act No.3 of 2006 also bears some discriminatory provisions such as:

- Section 26: Criminalizes deliberate transmission of HIV.
- Section 43: Intentional and Unlawful Acts (3c) Criminalizes deliberate transmission of HIV

Penal Code Section 186 criminalizes spreading of infection or of any disease dangerous to life, including HIV

HIV and AIDS Prevention and Control Act No. 14 of 2006, revised 2012

- Section 24 Prevention of Transmission criminalized transmission of (Suspended in 2015).

3.3.2. Freedom from Stigma and Discrimination

a. The People Living with HIV Stigma Index (SI) studies

The People Living with HIV Stigma Index (SI) studies measure and detect HIV-related, and more recently TB-related stigma and discrimination against people living with HIV and people with TB. The SI studies show that stigma and discrimination has not yet been eliminated and remain key concerns for people living with HIV and TB and for key populations.

A review of the findings of the Stigma Index studies illustrates the many dimensions of stigma and discrimination and how these undermine access to health care and other services. Surveys indicate that discrimination in health-care settings still occurs, especially towards key populations.

The SI studies also illustrate the role that self-stigma plays in the lives of people living with HIV: they experience shame and feelings of guilt and a lack of self-esteem which prevent them from engaging in relationships and/or having children. Women are especially vulnerable to stigma in their relationships, communities, and health care settings. There is also increasing evidence of TB-related stigma, especially amongst already stigmatized groups[55].

HIGHLIGHTS

SD Index Drop from 45% (2014) to 23% (2021)

Sex Workers (SW) had high rates of Stigma & Discrimination

- 1 in 3 SW Emotional Violence
- 1 in 4 SW Physical Violence; Discrimination
- 1 in 5 SW avoided HF due to S/D
- 1 in 5 SW Blackmail

1 in 5 Transgender Community experienced:

- Physical Violence
- Avoided HF due to S/D

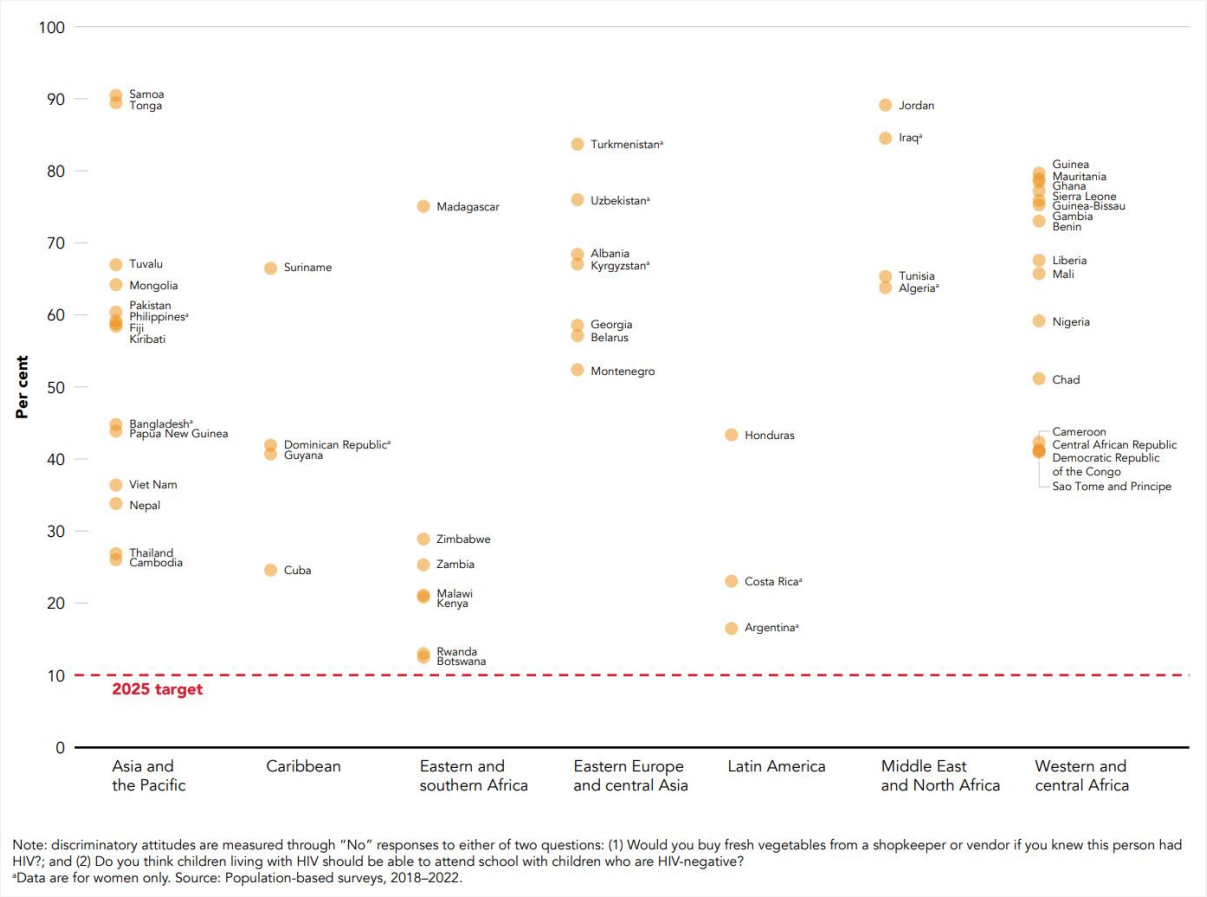
1 in 5 PWID avoided HF due to Stigma and Discrimination

The overall stigma index for Kenya in 2014 was 45% while the findings of the latest PLHIV stigma survey index is at 23%.

The most reported form of stigma or discrimination experienced by PLHIV due to their status included: being subjected to discriminatory remarks or gossip by either family (20%) or non-family members (24%) and verbal harassment (20%).

Notably, within the Southern and East Africa region, no country had reduced the levels of stigma and discrimination to the 2025 target of less than 10% as in Figure 16 below.

Figure 15: Percentage of men and women aged 15–49 years with discriminatory attitudes towards people living with HIV



Note: discriminatory attitudes are measured through "No" responses to either of two questions: (1) Would you buy fresh vegetables from a shopkeeper or vendor if you knew this person had HIV?; and (2) Do you think children living with HIV should be able to attend school with children who are HIV-negative?
[a]Data are for women only. Source: Population-based surveys, 2018–2022.

Source: UNAIDS

b. Breaking Barriers Initiative by The Global Fund

The Global Fund investments support interventions that aim to reduce new HIV infections by 75%, AIDS-related mortality by 50%, **HIV-related stigma and discrimination by 25%** and significantly increase domestic financing of Kenya's HIV response. Two HIV grants in Kenya were allocated funding for 2021-2024 of up to a combined total of US$264 million.

Throughout this effort, the Global Fund worked and continues to work with government, CCM members, key and vulnerable populations and technical partners towards better understanding of the programs to remove barriers, including which activities are most effective, how these can best be integrated into national plans and grants, the costs of such activities, and ways to overcome challenges of implementation and evaluation.

This is also coordinated through the Human Rights and Gender Technical Working Group on HIV, TB and malaria under NASCOP.

Baseline assessment across the three thematic areas (HIV, TB and Malaria) was conducted in Kenya in 2017 alongside 19 other countries; while the mid-term assessment was conducted in 2020/21.

i. HIV Assessment

The assessment explored the following themes; Stigma and Discrimination; Capacity building among health workers on human rights and medical ethics; Sensitization of legislators; Legal literacy; Legal services; Monitoring and reforming policies and laws; and Reducing HIV-Related gender discrimination and violence against women and girls.

Table 2: Assessment of Barriers to HIV SE Programming

Programme Description	Score		
HIV Programme Area	**Baseline**	**Mid Term**	**Trend**
Stigma and Discrimination Reduction	2	3.5	
Training of health care workers in human rights and medical ethics	2	2.5	
Sensitization of lawmakers and law enforcement officials	2	3	
Legal Literacy ("know your rights")	1	2.5	
Legal Services	2.5	3.5	
Monitoring and reforming policies, regulations and laws	3	4	
Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity	2	2.5	

Source: Global Fund

Highlight: While there has been some improvement across all dimensions, most interventions were either small scale or sub-national level (score less than 4) in their reach except for Monitoring and reforming policies and laws.

ii. Tuberculosis Assessment

The assessment explored the following across the disease themes; Stigma and Discrimination; Capacity building among health workers on human rights and medical ethics; Sensitization of legislators; Legal literacy; Legal services; Monitoring and reforming policies and laws; Reducing TB Related discrimination against women; Ensuring confidentiality and privacy; Mobilizing and empowering patient and community groups; Rights and access to TB services in prisons.

Table 3: Assessment of TB SE Programming

Programme Description	Score		
TB Programme Area	**Baseline**	**Mid Term**	**Trend**
Stigma and discrimination reduction	3	3	
Training of health care workers on human rights and medical ethics related to TB	1	2	
Sensitization of lawmakers and law enforcement officials	1	1.5	
Legal Literacy ("know your rights")		1.5	
Legal Services		1.5	
Monitoring and reforming policies, regulations and laws related to TB	1.5	2	
Reducing TB-related discrimination against women	0.5	1	
Ensuring confidentiality and privacy		1	
Mobilizing and empowering patient and community groups	2	3	
Rights and access to TB services in prisons	1	1.5	

Source: Global Fund

Highlight: The progress has been marginal across all dimensions, but most interventions were either small scale or sub-national level in their reach (scores below 3). The highest scores were in stigma and discrimination reduction; and Mobilizing and empowering patient and community groups. The lowest scores were in Reducing TB Related discrimination against women; and Ensuring confidentiality and privacy.

iii. Malaria

The assessment explored the following themes; Reducing gender related barriers and harmful gender norms; Promoting meaningful participation of affected populations; Strengthening community systems for participation in Malaria programs; Malaria programs in detention; and Improving access to services

Table 4: Assessment of Malaria SE Programming

Programme Description	Score		
Malaria Programme Area	**Baseline**	**Mid Term**	**Trend**
Reducing gender-related barriers and harmful gender norms		0.5	
Promoting meaningful participation of affected populations	0.5	1.5	
Strengthening community systems for participation in malaria programs		2	
Malaria programs in prisons and pre-trial detention			
Improving access to services for underserved populations, including for refugees and others affected by emergencies	1	1	

Source: Global Fund

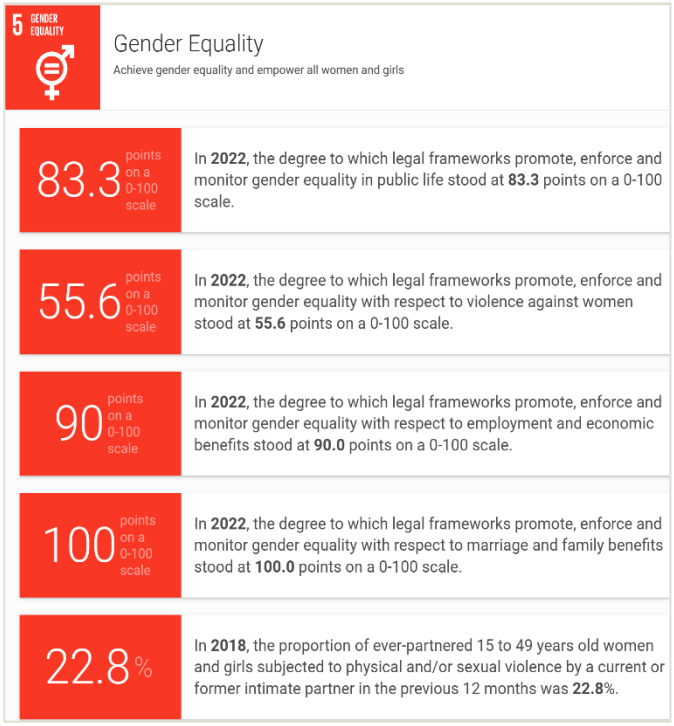
Highlight: The progress has been very minimal across all dimensions, and most interventions were on a small scale in their reach (scores below 2). The highest score was in Strengthening community systems for participation in Malaria programs. The lowest score was in reducing gender related barriers and harmful gender norms. There was limited data on programs in prison and pre-trial detention.

3.3.3. Gender Equality

Gender equality is the achievement of equal rights, opportunities, and outcomes for women and girls in all areas of life. This includes ending all forms of discrimination against women and girls, promoting their full participation in society, and ensuring that they have access to the resources and services they need to thrive. It is a fundamental human right and essential for achieving sustainable development.

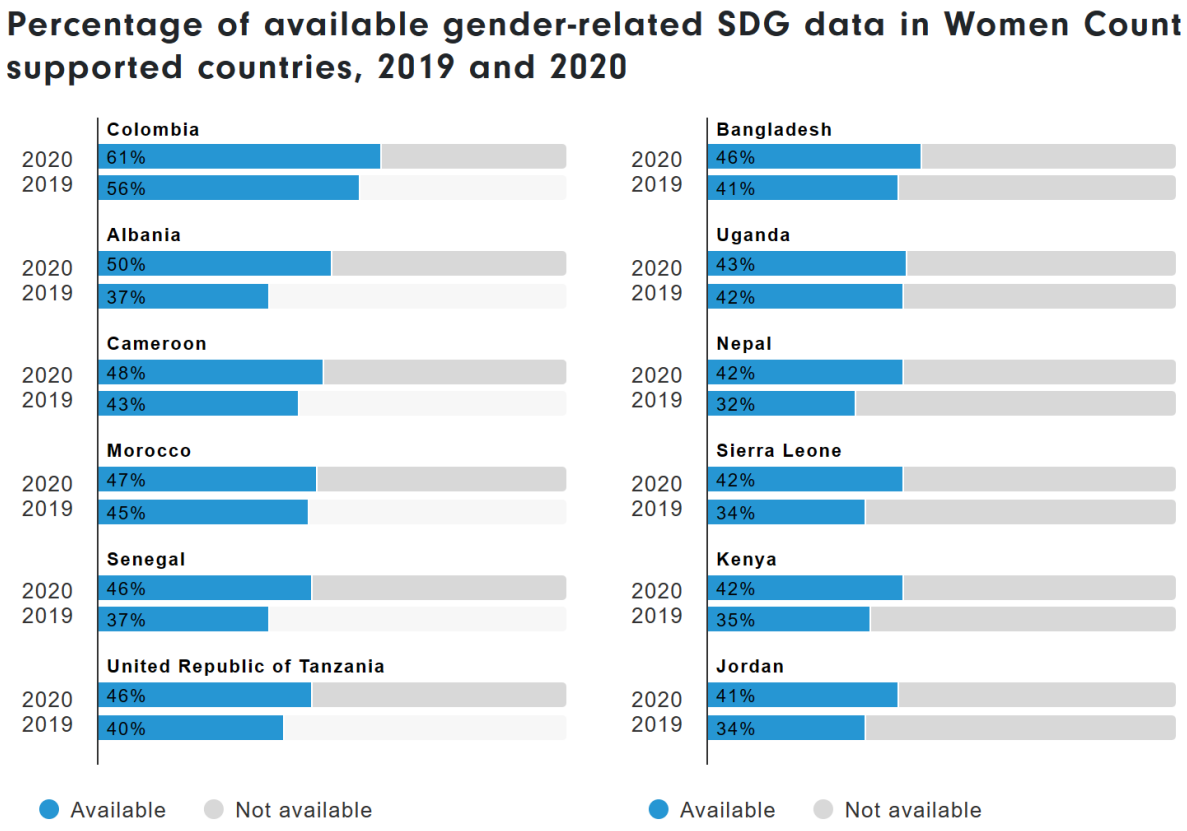
The UN SDG Monitor tracking global progress in Gender Equality highlights the following on Kenya's profile in 2022:

Figure 16: Kenya Country Profile on Gender Equality



- The average score for legal frameworks promoting gender equality in public life was 83.3 points on a scale of 0 to 100
- The degree to which legal frameworks promote, enforce and monitor gender equality with respect to violence against women stood at 55.6 points on a 0-100 scale.
- The average score for gender equality in legal frameworks with respect to marriage and family benefits was 100 points
- The degree to which legal frameworks promote, enforce and monitor gender equality with respect to employment and economic benefits stood at 90 points
- The degree to which legal frameworks promote, enforce and monitor gender equality with respect to marriage and family benefits stood at 100 points
- In 2018, the proportion of ever-partnered 15 to 49 years old women and girls subjected to physical and/or sexual violence by a current or former intimate partner in the previous 12 months was 22.8%.
- The proportion of seats held by women in single or lower houses of parliament increased from 3.6% in 2000 to 23.3% in 2023.

Figure 17: Availability of Gender related data



Source: Women Count Data Hub

Further, on availability of gender-related SDG data across 72 gender specific indicators, there was a notable improvement in Kenya from 35% in 2019 to 42% in 2020 as in figure.

Highlight: While there is significant progress made towards gender equality, more needs to be done to a) reduce and eliminate gender-based violence; and b) improve gender data availability and integrity in Kenya.

3.3.4. Co-action across development sectors to reduce exclusion and poverty

a. Vision 2030

The overall aim of the Kenya Vision 2030 is to transform the country into a newly industrializing middle-income country providing a high quality of life to all its citizens in a clean and secure environment.

The Social pillar of Vision 2030 aims to improve the quality of life for all Kenyans by targeting a cross-section of human and social welfare projects and programmes. This pillar recognizes the multisectoral nature of progress and transformation through eight key social sectors, namely; Education & Training, Health, Water & Sanitation, Environment, Housing & Urbanization and Gender, Youth, Sports & Culture.

b. Bottom-Up Economic Transformation Agenda (BETA) Approach

BETA adopts a multi-sectoral approach to development by targeting sectors with the most impact to drive economic recovery to be achieved through six objectives: bringing down the cost of living; eradicating hunger; creating jobs; expanding the tax base; improving foreign exchange balances; and inclusive growth.

c. The National AIDS Control Council Strategic Plan 2021/2022 – 2026/2027

This strategy prioritizes a multi-sectoral approach to policy review and development for effective HIV prevention and control as its first strategic priority.

For effective delivery of KASF II, NACC established a coordination framework at all levels. It proposed that the coordinating committees will be multi-sectoral to ensure key stakeholders are represented ranging from the public sector, private sector, civil society, development, and implementing partners. Key and vulnerable populations including people living with HIV will be included in each of the coordination groups.

d. National Multisectoral HIV Prevention Acceleration Plan 2023–2030

The National Multisectoral HIV Prevention Acceleration Plan 2023–2030 prioritizes investments in sustaining a multi-sectoral approach to HIV prevention at the national and sub-national level in Kenya.

3.3.4. Barriers

Challenges to Societal Enabler Programming in Kenya highlighted by stakeholders during the assessment include the following:

Legal and Regulatory Hurdles: Restrictive laws and regulations, along with a lack of enforceable legal protections, present significant obstacles to the advancement of Societal Enabler programming. These legal constraints hinder initiatives in areas such as Sexual and Reproductive Health and Rights (SRHR).

Political Resistance and Conservative Ideologies: Political opposition from leaders and conservative groups, driven by ideologies, acts as a formidable barrier to SRHR and societal enabler programming. The lack of political will to support progressive initiatives compounds this challenge.

Stigma, Discrimination, and Social Barriers: Stigmatization and discrimination contribute to societal enabler programming challenges by creating barriers to participation and engagement. These societal biases can particularly affect SRHR initiatives.

Inadequate Legal Support and Evidence Presentation: The absence of strong legal support and the insufficient presentation of evidence during policy-making processes further hinder progress. This deficiency can lead to exclusion of critical issues and ineffective policy development.

Accountability Deficits: A broader challenge is the lack of robust accountability mechanisms. This deficiency undermines the effectiveness of societal enabler programs, as there is perceived limited oversight and accountability for their implementation.

3.4. Recommendations

The following are recommendations for strengthening Community Leadership and Societal Enabler Programming in Kenya:

1. Intersectional Approach: Implementing and structuring societal enabler programming and Community Leadership requires an intersectional approach that recognizes the interconnectedness of various social and identity-related factors e.g., identity, gender inequality, stigma and discrimination, education, income, and geographical inequalities. This means considering multiple dimensions of identity and addressing their intersections in program design and implementation.

2. Partnerships and Collaborations: Building partnerships and collaborations with diverse yet aligned organizations and stakeholders is crucial to ensure that programming is comprehensive. Working together with different groups, including grassroot level mobilization allows for a more comprehensive and inclusive approach.

3. Embracing Diversity and Inclusion in Leadership: Diversity in the CLSE programming leadership is essential as it may bring a variety of perspectives and experiences to the cause, ensuring that the program's impacts are more inclusive, contextual and relevant to a wide range of identities, issues and interests.

4. Capacity Building and Empowerment: Continuous capacity-building to individuals and organizations involved in CLSE programming is critical. This will ensure that they are empowered with the appropriate knowledge and skills needed to address the programming challenges effectively. This empowerment includes strategies like human rights education, resource mobilization, data driven advocacy, data management and community resilience building. Empowerment efforts should particularly focus on vulnerable groups to address their unique challenges.

5. Awareness and Education: Creating awareness and promoting clear understanding of the prevailing Community Leadership and SE context among stakeholders and the public is crucial. It helps in highlighting the importance of addressing issues affecting effective Community Leadership and Societal Enabler programming and can lead to increased support.

6. Advocacy for Intersectionality: Advocacy efforts should emphasize the importance of intersectionality in addressing societal issues. This includes advocating for policies and practices that consider the diverse identities and experiences of individuals and communities.

7. Evaluation and Learning: Regular evaluation and learning processes should be integrated into the Community Leadership and Societal Enabler programming. This will allow for ongoing assessment of the program's effectiveness and enables adjustments as needed.

8. Advocacy and Policy Reforms: Advocacy efforts should focus on a) repealing discriminatory laws and policies; b) establishing policies to support community leadership e.g., review, approval and dissemination of the national CLM framework. This will include data-driven advocacy, and strategic litigation to bring about legal and policy reforms.

9. Social Media and Technology: The use of social media as a form of advocacy can help amplify messages and reach a wider audience. Embracing technology and innovative communication methods can enhance the effectiveness of CLSE programming.

10. Advocacy for increased resources: Effective implementation of CLSE programming is a resource intensive hence the need for increased funding from government and partners.

The ongoing donor transitions further necessitate urgent and progressive increases in government allocations to CLSE programming.

11. Geographical Inclusion: Ensuring geographical inclusion of CLSE programming across the country is important for equitable access to resources, services and opportunities. It will require cascading interventions and information to grassroot level across the country with a view to improving awareness, participation and impact.

4.CONCLUSION

The exploration of Community Leadership and Societal Enabler programming in Kenya reveals both promise and hurdles. While local and donor-funded efforts demonstrate commitment, the reliance on external funding poses a notable risk to sustainability.

In addressing the challenges, success is hinged on increased government financing and support. Despite multiple initiatives aiming for inclusivity, persistent challenges like stigma, discrimination, data gaps, capacity limitations, and restrictive legal frameworks necessitate a collective effort. The imperative for a resilient local commitment becomes even more apparent in the face of substantial external funding.

These challenges, though significant, set the stage for the next crucial phase: developing a responsive contextual advocacy roadmap. The roadmap, addressing collaboration gaps, legal barriers, and promoting inclusivity, is essential to sustained progress. By amplifying government support and reducing dependence on external funds, Kenya can forge a path towards a healthcare system that is sustainable, equitable, and responsive to the diverse needs of its communities.

Annex 1: Data Collection Tool

Annex 2: Respondents

Survey Respondents	
Organization	**Designation**
Reproductive Health Network Kenya	Youth Advocate
Reproductive Health Network Kenya	A volunteer
Positive Young Women Voices	Volunteer
Reproductive Health Network Kenya	Youth Advocate
Smartladies cbo Nakuru	Director
Youth advisory Council Nairobi	Youth Advocate
Trans*Sisters Network Nakuru	Programs Director
Inclusivity, Diversity & Equity Advocacy Organisation (IDEAo)	Team Lead
Reproductive health network Kenya	Youth Advocate
Positive Young Women Voices	Podcaster and Youth Advocate
2 Anonymous	
KP & CSO Convening Representatives	
Organization	**Number**
AHF-KENYA	1
AMREF	1
AYARHEP	5
BHESP	2
CKDN	1
COG	1
COMMUNITY	1
EGPAF	1
GIGI	1
HENNET	2
HERAF	1
INERELA KENYA	1

Survey Respondents	
ISHTAR	1
JINSIANGU	1
KANCO	6
KCCB	1
KENPUD	1
KETAM	1
KIPOTEC	1
KP CONSORTIUM	2
KWKENYA	1
LEHA KENYA	1
MATOPENI SELF HELP GROUP	1
MOC	1
MSF-BELGIUM	1
NADHARIA KENYA	1
NEPHAK	2
NERMA KENYA	1
OPERATION HOPE CBO	1
PATH	1
POSITIVE YOUNG WOMEN VOICE	1
PS KENYA	1
REPRODUCTIVE HEALTH NETWORK KENYA	2
SCALING UP NUTRION (SUN CSA)	1
SWOP AMBASSADOR	1
THE QUEER REPUBLIC	1
YOUNG ADVISORY COUNCIL NAIROBI	1