

KENYA PrEP COMMUNICATIONS LANDSCAPE ANALYSIS

What do we know and what do we need to know?

*McCann Global Health
Prepared for the Technical Working Group
January 27, 2017*



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OVERVIEW

The Optimizing Prevention Technology Introduction on Schedule (OPTIONS) consortium is one of five projects funded by USAID, in partnership with the PEPFAR to expedite and sustain access to antiretroviral-based HIV prevention products by providing technical assistance for investment scenarios, market preparation strategies, country-level support, implementation science and health systems strengthening in countries and among populations where most needed.

A key aim within OPTIONS is to develop a market preparation and communications guide for the introduction and uptake of PrEP in Kenya, led by the OPTIONS partners including FHI 360, McCann Global Health, and LVCT Health in Kenya.

With support from PrEP TWG, McCann Global Health will conduct a national market intelligence study and support the development of a national market preparation and communications strategy to support demand creation efforts of PrEP in Kenya. This strategy aims to offer a cohesive, strategic, and coordinated launch of PrEP as well as forthcoming ARV prevention products in Kenya.

Prior to the start of the market intelligence, McCann has conducted a landscape analysis of all available communications about the target audiences, HIV prevention, and PrEP in Kenya, to identify key knowledge gaps for further exploration in the market intelligence. The following presentation outlines findings from the landscape analysis.

WHERE WE ARE

As the first step in a larger market preparation and communications plan, and in accordance with our 5C Process, McCann Global Health (New York) has conducted a landscape analysis of available information and knowledge on the demand creation and uptake of PrEP among vulnerable populations in Kenya, including serodiscordant couples, adolescent girls and young women, men who have sex with men, female sex workers and people who inject drugs. In addition to vulnerable populations, we also researched health care workers as the gatekeepers to HIV prevention products, services and information.

The objective of the landscape analysis is to uncover and/or confirm key findings, insights, tension points, gaps and needs for further investigation.

In order to deeply understand and build upon previous research that explored our targets' motivations and attitudes regarding HIV prevention behaviors and products, we:

1. Conducted multiple qualitative interviews with key stakeholders in Kenya and
2. Performed desk research which entailed collecting and reviewing all pertinent and available published and gray literature, including research, governmental and organizational reports, conference proceedings, working papers, white papers, evaluations, partner literature reviews etc.

In short, we dug in the places that mattered from the unique perspective of understanding insights about PrEP communications!

WHERE WE ARE

WHERE WE ARE GOING

Conduct market intelligence that supports the development of an evidence-based and insight-driven communications strategy for driving demand of the PrEP category in Kenya.

LANDSCAPE ANALYSIS

5C ANALYSIS

CREATIVE BRIEF DEVELOPMENT

MARKET INTELLIGENCE

MARKET PREPARATION AND COMMUNICATIONS STRATEGY DEVELOPMENT

COMMUNICATIONS GUIDE DEVELOPMENT

STAKEHOLDER INTERVIEWEE LIST

Anabel Gomez, Global Marketing Manager, AVAC

Elizabeth Bukusi, Senior Research Officer, Medical Research Institute

Connie Celum, Principal PrEP Investigator, University of Washington

Lucy Ghati, Program Manager, NEPHAK/Kelin Organization

Grace Kamau, Project Officer, KP Consortium

Brian Macharia, GALCK

Mercy Kamau, Program Manager, Jilinde

Daniel Were, Development Communications Specialist, Jhpiego

*Peninah Mwangi, Executive Director, Bar Hostess Empowerment and
Support Programme*

Michael Ighodaro, Program and Policy Assistant, AVAC

Brandon Kimani, PrEP Ambassador and MSM Peer Educator

Caroline Ng'eno, Regional Director, ICAP

SUMER

JTH

CULTURE

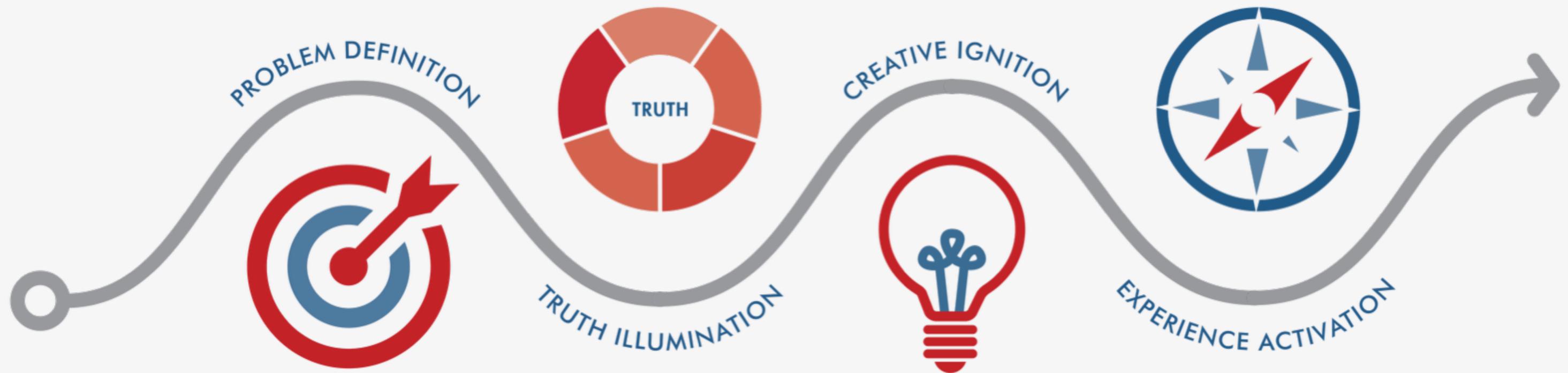
ONS

ABOUT THE 5 C'S

TRUTH 2 MEANING

We start with the central problem and work to identify the drivers around that problem, uncovering the core truths across the category, culture, connections, company and consumer.

From there, the truths lead to a powerful communications strategy that informs communications for the target audiences.



CONDUCTING A TRUTH AUDIT

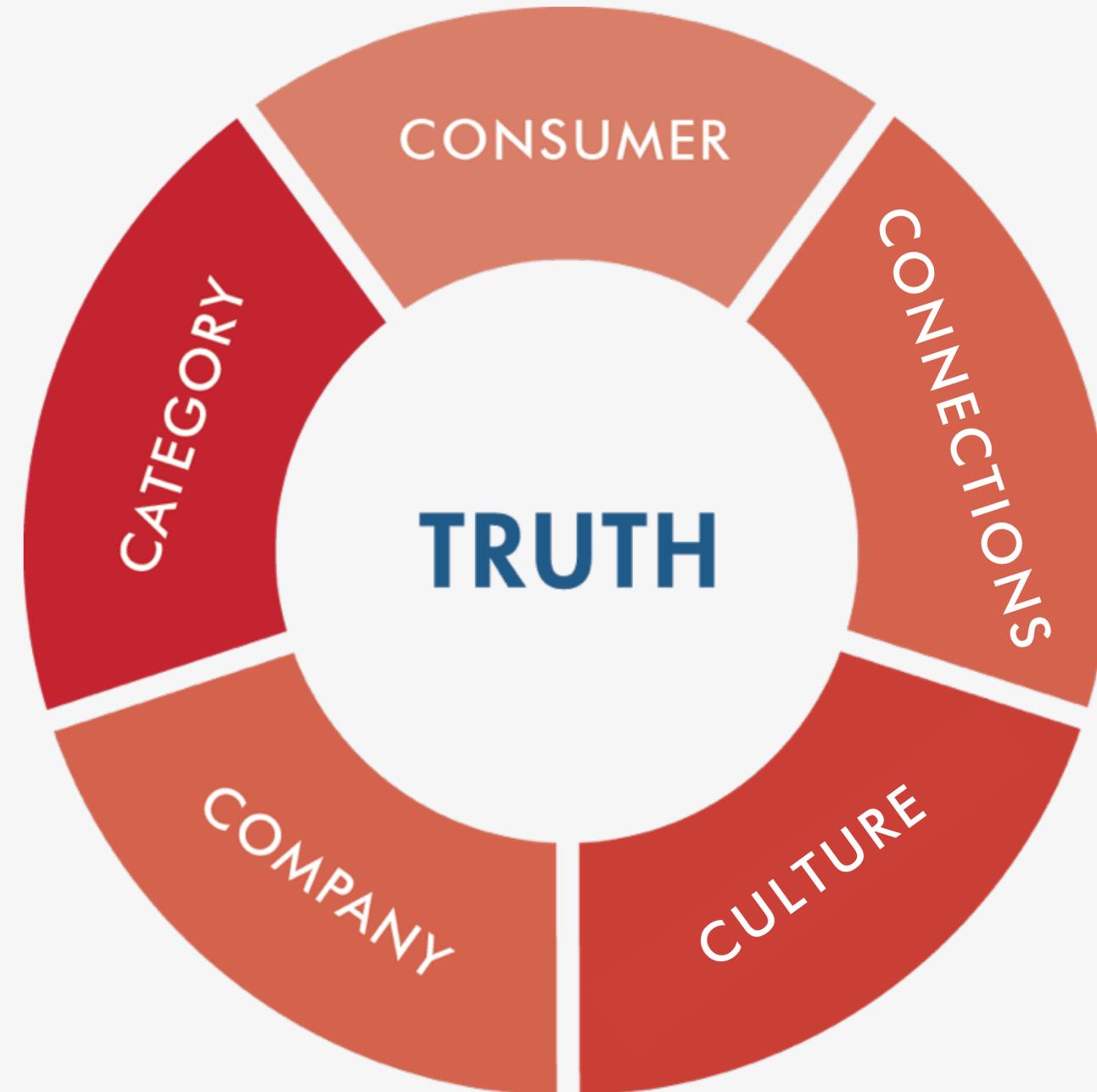
A disciplined strategic process of digging in the places that matter.

CATEGORY

- Characteristics, dynamics, and conventions
- HIV prevention's competitive set

COMPANY

- Overview of the PrEP category and its competitive set
- Consumer perceptions towards PrEP
- Potential opportunities for PrEP



CONSUMER

- Our target market
- Their motivations, interests, and influences
- Their attitude toward HIV prevention, sex, and sexual and reproductive health

CONNECTIONS

- Channel preferences
- How consumers connect with one another and their influencers, as well as any other influential factors

CULTURE

- Cultural barriers or differences to overcome
- Cultural trends affecting our consumer's attitudes and behavior

THE 5 C'S

CULTURE

Understanding the consumers as a whole must go beyond the individual, as cultural beliefs are one of the strongest forces shaping the consumer mindset. Sometimes they work in our favor, but they can also signify potential hurdles.

CONSUMER

Foundational understanding of consumers beyond demographics to include attitudes/beliefs and behaviors.

CONNECTIONS

Understanding how consumers interact and influence each other, as well as the impact from other sources.

CATEGORY

Seeing the category through the eyes of the consumer, as well as competitors within the category, can help uncover points of tension and opportunity for our efforts.

COMPANY

The product, organization or offering (PrEP), and the perceptions surrounding them.

CULTURE

*Cultural beliefs or trends
shaping our consumer
mindsets and behavior.*

ISUMMER

ECTIONS

CULTURE THEMES

RELIGION DOMINATES BELIEFS ABOUT SEX BUT NOT NECESSARILY BEHAVIOR

MELTING POT OF ETHNIC CULTURES

YOUTH AS A CHALLENGE AND OPPORTUNITY

OPTIMISM RULES

AFRICAN TREND: RAPID URBANIZATION

MUSIC: KEY COMPONENT OF KENYAN LIFE

THE RISE OF HEALTHY

RELIGION
DOMINATES BELIEFS
ABOUT SEX BUT NOT
NECESSARILY
BEHAVIOR



RELIGION IS A CRUCIAL PART OF THE EVERYDAY LIVES AND CULTURAL FABRIC OF KENYAN SOCIETY

RELIGION IS PERVASIVE:

- **97%** of the population ascribes to a religion.
- A recent Pew Forum [survey](#) indicates that **82% of Kenyans consider religion to be 'very important'** in their life and **70%** attend weekly religious services.
- Interestingly, about **19%** of the Christian population in Kenya uses traditional religious healers. However, the credibility of religious institutions insofar as faith healing may now be weakening due to the perception that religious leaders are only after material gain.

RELIGIOUS HEALERS

- Religious healers can act against the rollout of PrEP by, for example, encouraging PLHIV to pray for their recovery.
- At one evangelical church in Nairobi, Kenya, the leader charged between **\$3K - \$4K** to perform prayers to cure them of HIV.
- Interventions that are most likely to change peoples' views on faith healing can involve religious leaders who encourage condom use but also offer faith healing as part of a holistic approach to people's health.

Kenya 'miracle healer' scandal hits deep faith in churches

An expose has raised a furor over a self-styled prophet's exploitation of poor people. While such cases are not new, this latest has prompted a sharp reaction.

By Ariel Zirulnick, Correspondent | NOVEMBER 20, 2014

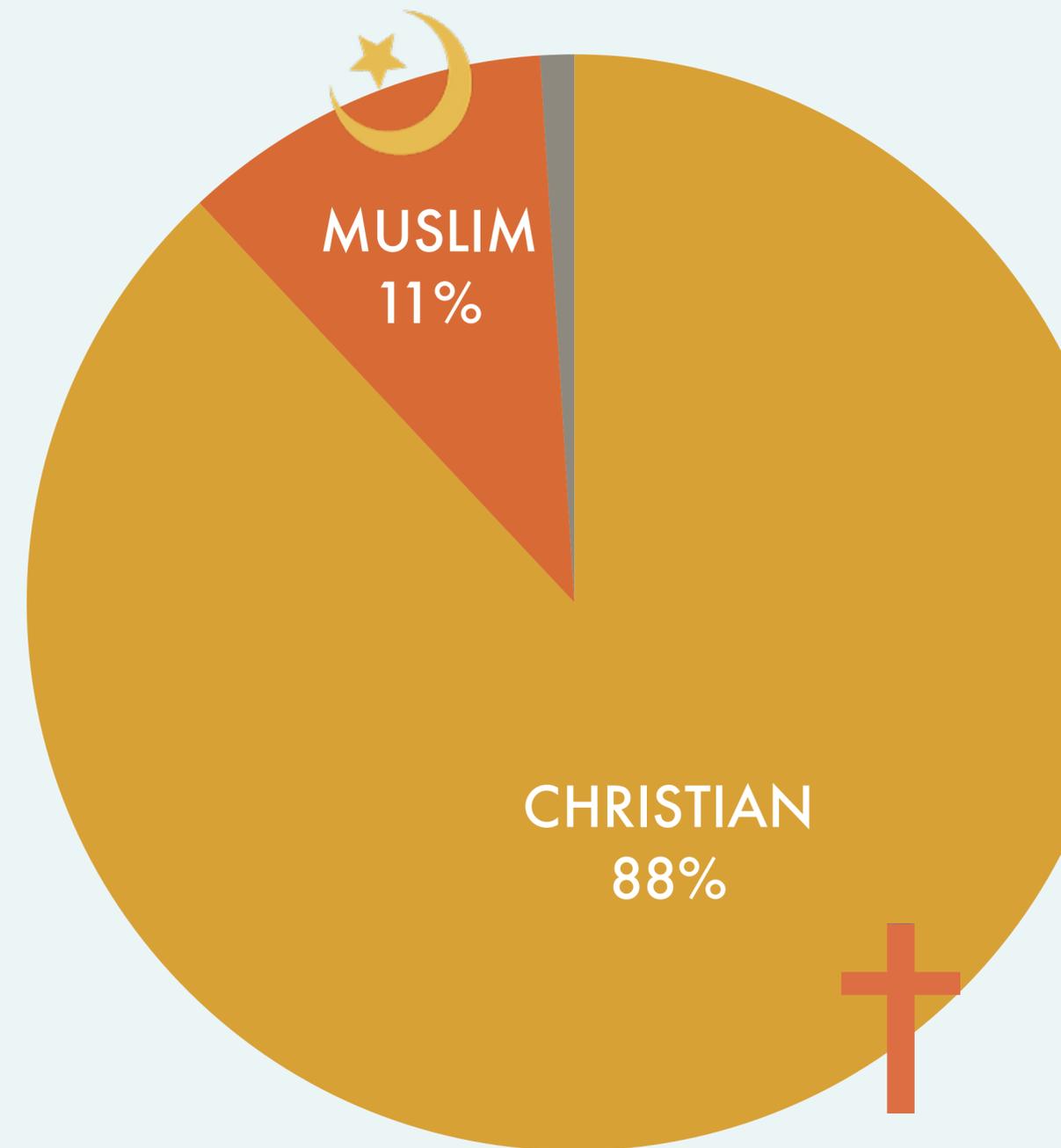
Save for later

RELIGIOUS ORGANIZATIONS MAY WELL BE THE MOST RESILIENT, DURABLE, AND WIDESPREAD DEVELOPMENT ACTORS IN KENYA

- The [faith-based organizations](#) Kenya Conference of Catholic Bishops (KEC) and Christian Health Association of Kenya (CHAK) provide more than **40%** of the country's health services (as of 2007).
- The Catholic Church reports that it operates **28%** of the nation's primary schools and over **30%** of its secondary schools. The Christian Health Association of Kenya and the Kenya Council of Catholic Bishops also run an extensive network of health facilities. But, faith actors' reach extends not just to health and education; faith-inspired organizations are deeply involved in almost any development topic or sector.
- Kenya has an estimated **30,000** faith-inspired organizations which implement development programs of many kinds through established church structures, religious leader initiatives, and faith communities. **As community spokespersons, they often are successful in mobilizing for positive social change.**
- Apart from reaching their constituents in church, key populations are reached by churches through events such as youth camps, youth groups etc., with some even having their own media stations to reach people at scale e.g. Nairobi Pentecostal Church with Hope FM radio.
- Their extensive networks and first-hand knowledge could be an opportunity for spreading messages about PrEP as part of a combination prevention strategy.

THE RELATIONSHIP BETWEEN RELIGION AND HIV/AIDS IS COMPLEX

- Some **11%** of Kenyans are Muslims while **88%** follow the Christian faith.
- **33%** of Kenyans believe that contraception is immoral.
- A very high percentage of adolescents agree that young men and women should remain virgins until marriage, however **85% of AGYW are sexually active.**
- The disconnect between beliefs and behavior is stark.



CONCURRENT/MULTIPLE PARTNERSHIPS ARE COMMON

- Men are much more likely than women to report having two or more sexual partners (Kenya Demographics and Health Survey, 2014)
- In the recent PrEP POWER research, most women said they don't have a "side" partner now, but they think most women have **2.9 partners** at one time. Most men say they have a side partner now (**77%**), and think most men have **4.8 partners** at one time.



MELTING POT OF DIFFERENT ETHNIC CULTURES



The country has at least **40** different ethnic African groups (including the Kikuyu, Luhya, Kalenjin tribes, Luo, Kamba, Somali, Kisii, Meru, Embu, Mijikenda, Turkana and Maasai) who speak a variety of mother tongues.

A PERSON'S ETHNICITY INFLUENCES THEIR ATTITUDES REGARDING CURRENT CONDITIONS IN KENYA

There is wide disagreement between ethnic groups over national conditions. The Kikuyu and Kalenjin people are much more content with current conditions than the Luhya and Luo. For example, at least half of the Kikuyu (**61%**) and Kalenjin (**53%**) say the economy is doing well, while just **34%** of Luhya and **19%** of Luo say the same. (PewGlobal.org)

ETHNICITY ALSO INFLUENCES VULNERABILITY TO HIV/AIDS

For example, there are certain traditions of the Luo tribe that are seen as heightening the risk of HIV transmission:

- Wife inheritance
- Sexual cleansing (sex with a male relative before a widow can be inherited or remarried, having sex with a virgin to cure HIV) etc.
- Traditionally do not practice male circumcision



YOUTH AS A CHALLENGE AND OPPORTUNITY

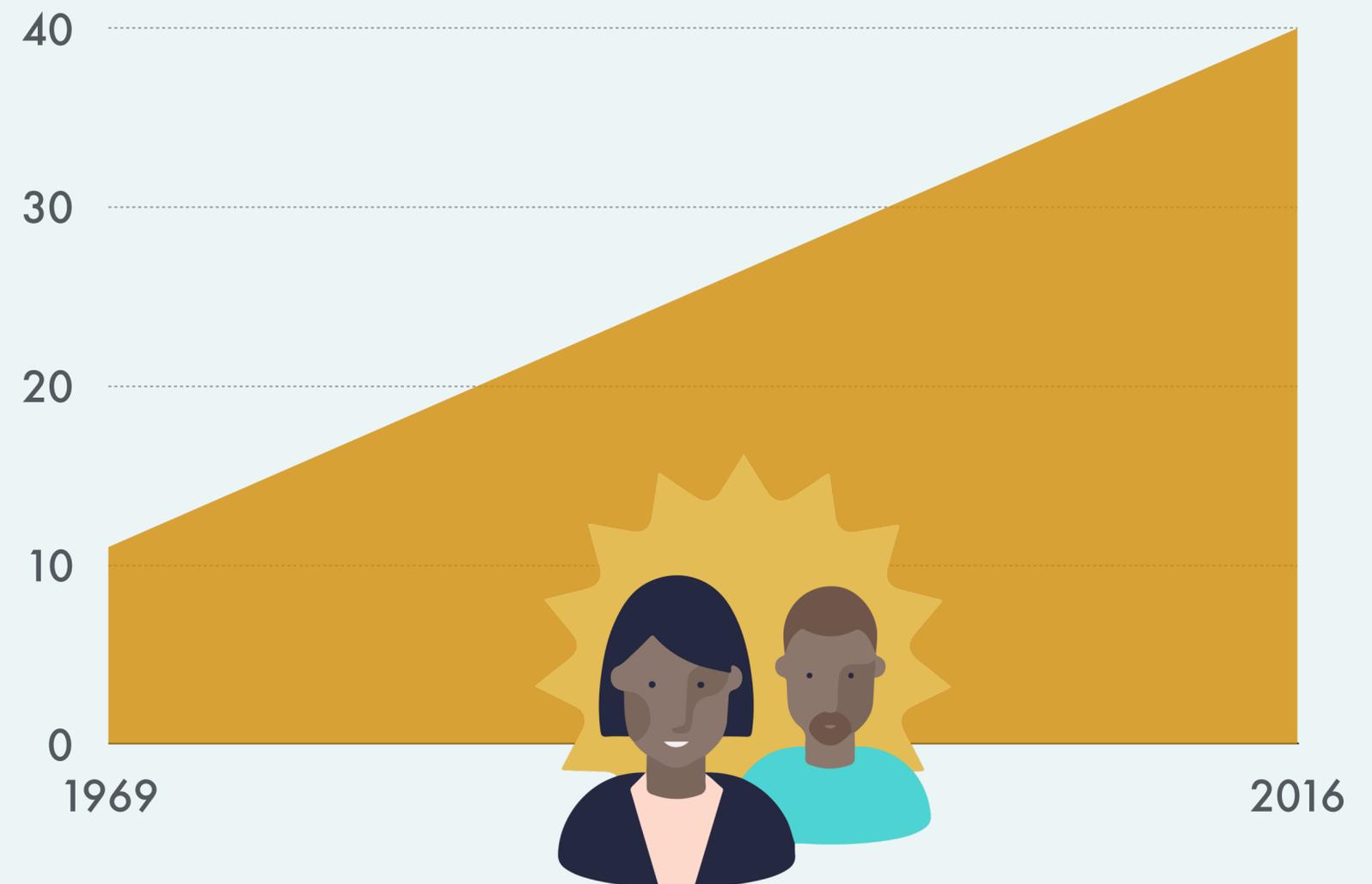
Kenya's young population represents a challenge in terms of access to sexual and reproductive health (SRH) and HIV information commodities and services. Yet, this burgeoning youth population is also the country's greatest asset.



THE POPULATION IS YOUNG AND EXPLODING

Kenya's population has been growing rapidly. In just the last four decades, the entire population has nearly quadrupled in size, from 11 million people in 1969 to about 40 million today.

Today, approximately **25 million people, nearly two out of three people, are under the age of 25.**



ENDURING SPIRIT OF INNOVATION AND ENTREPRENEURIALISM DRIVEN BY KENYA'S YOUTH

M-PESA

Kenya is leading the way in innovative mobile services (m-pesa). Nairobi is locally called 'Silicon Savannah', and has ambitions of becoming a global tech capital.

HOPE RAISERS

Two university students from Nairobi, Joseph Kuria and Daniel Onyango, added a skating sports programme to their neighborhood NGO called Hope Raisers. The two developed the idea after a UN project added paved roads to their neighborhood which wasn't congested with traffic. In a bid to keep the youth out of trouble, the two started a skating club and competition team which has become one of East Africa's largest.



OPTIMISM RULES



WHILE THERE IS MASSIVE UNEMPLOYMENT AND EXTREME POVERTY...

Poverty levels are between **44–46%**.

Kenya's unemployment rate stands at **40%**. The majority of the unemployed are the **YOUTH AND WOMEN**.

KENYA IS LEADING THE PACK IN CERTAIN AREAS



1. KENYA HAS ONE OF THE HIGHEST LITERACY RATES IN SSA:

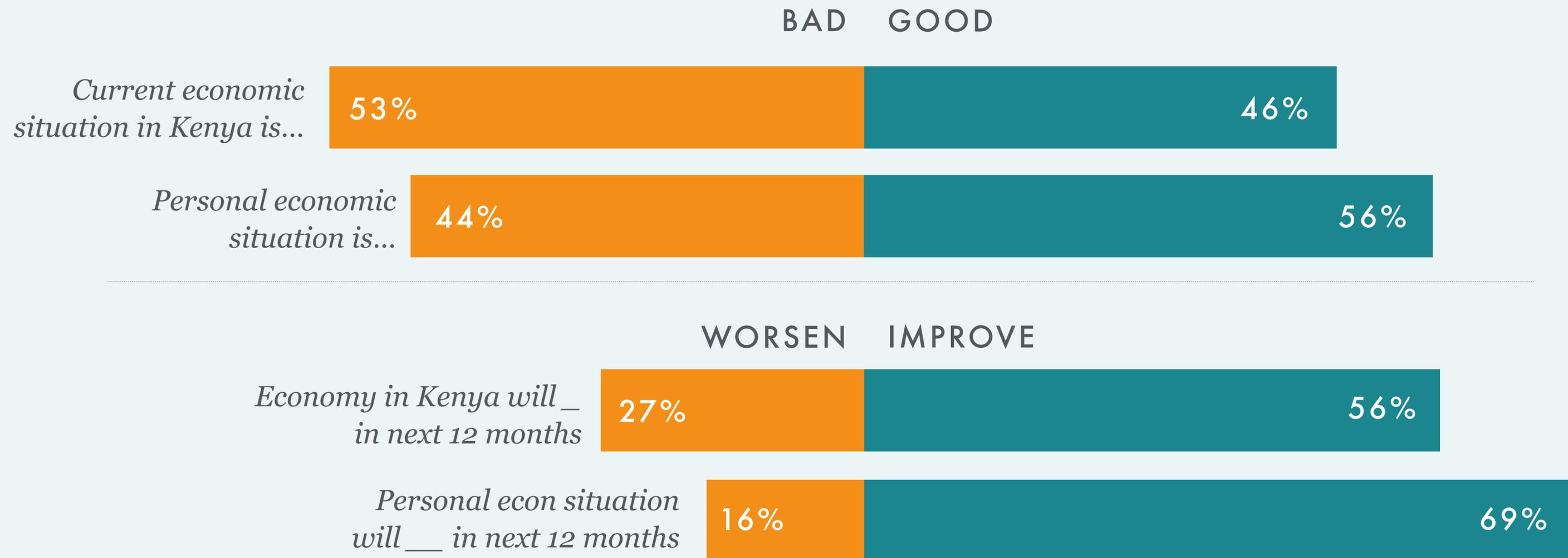
The youth literacy rate in Kenya is about **85%**, which is greater than its neighboring nations. For example, the youth literacy rate is **79%** in Uganda, **61%** in Sudan and **45%** in Ethiopia. (BBC.COM)

2. LEADING THE CHANGE IN AFRICAN ENVIRONMENTAL ACTIVISM:

Following footsteps of environmental activist Wangari Maathai, Kenya issued the Bonn Challenge: planting a forest the size of Costa Rica, 350MM hectares by 2030.



DESPITE CONCERNS, PEOPLE ARE VERY OPTIMISTIC ABOUT THE COUNTRY'S FUTURE



Source: Spring 2016 Global Attitudes Survey. q3, q4, q5 & q6
Pew Research center

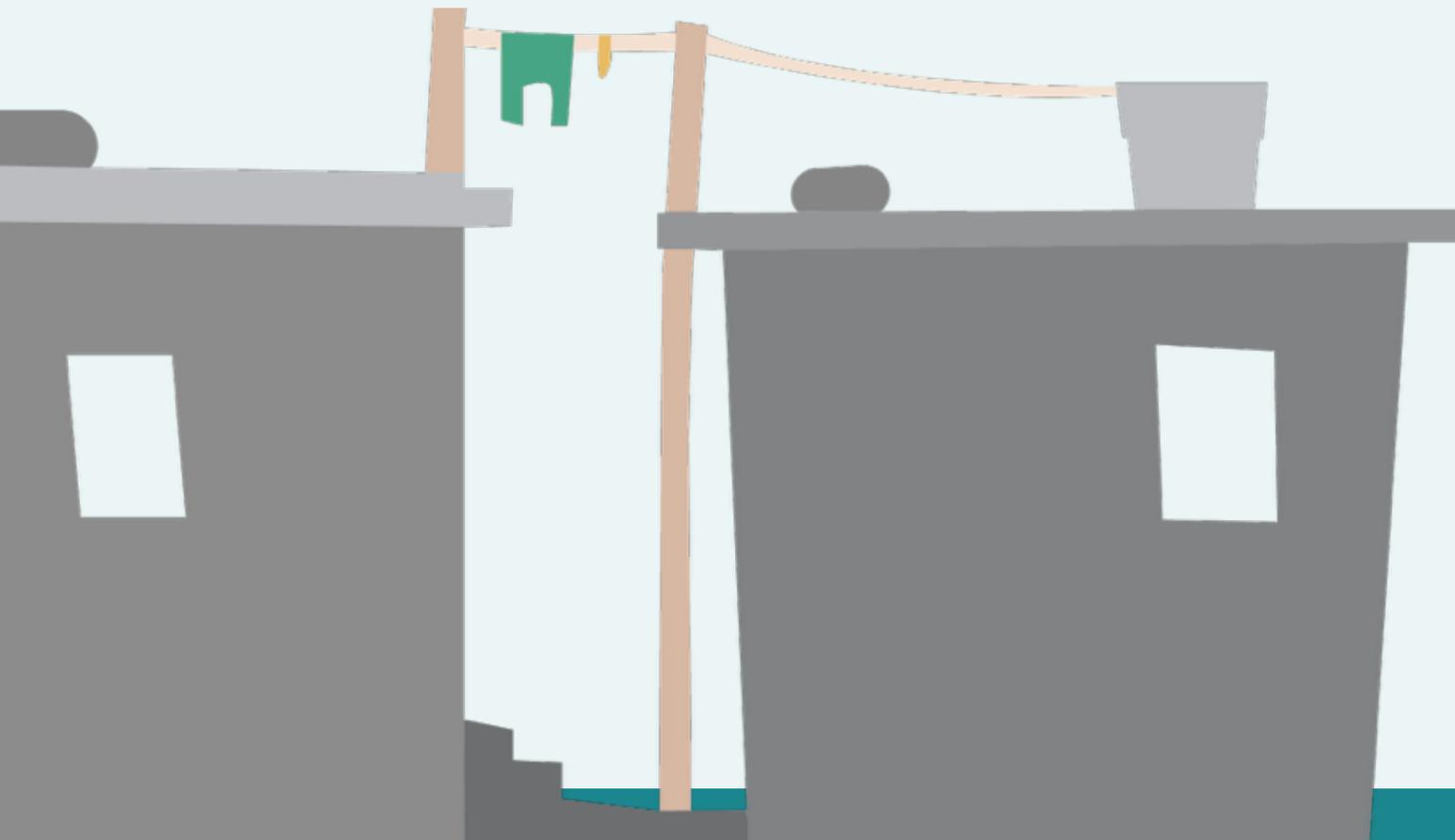
RAPID URBANIZATION



KENYA'S SLUMS

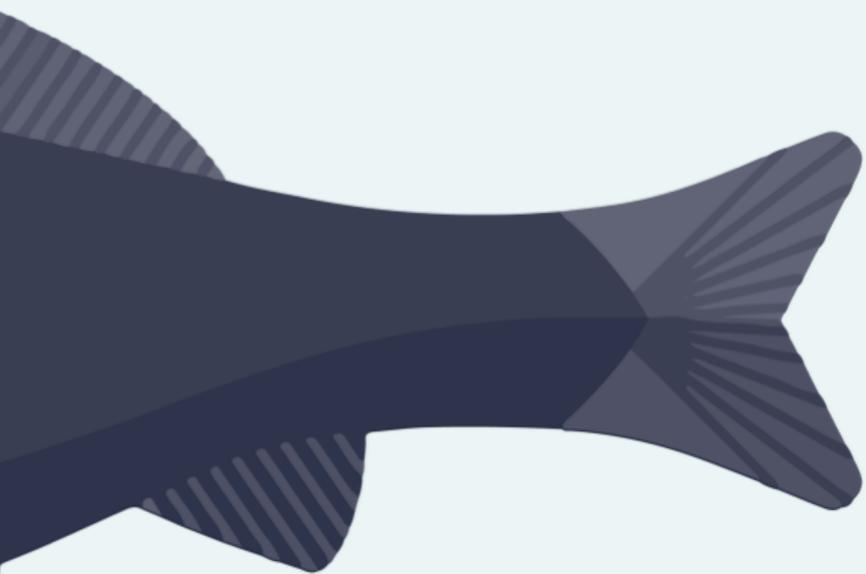
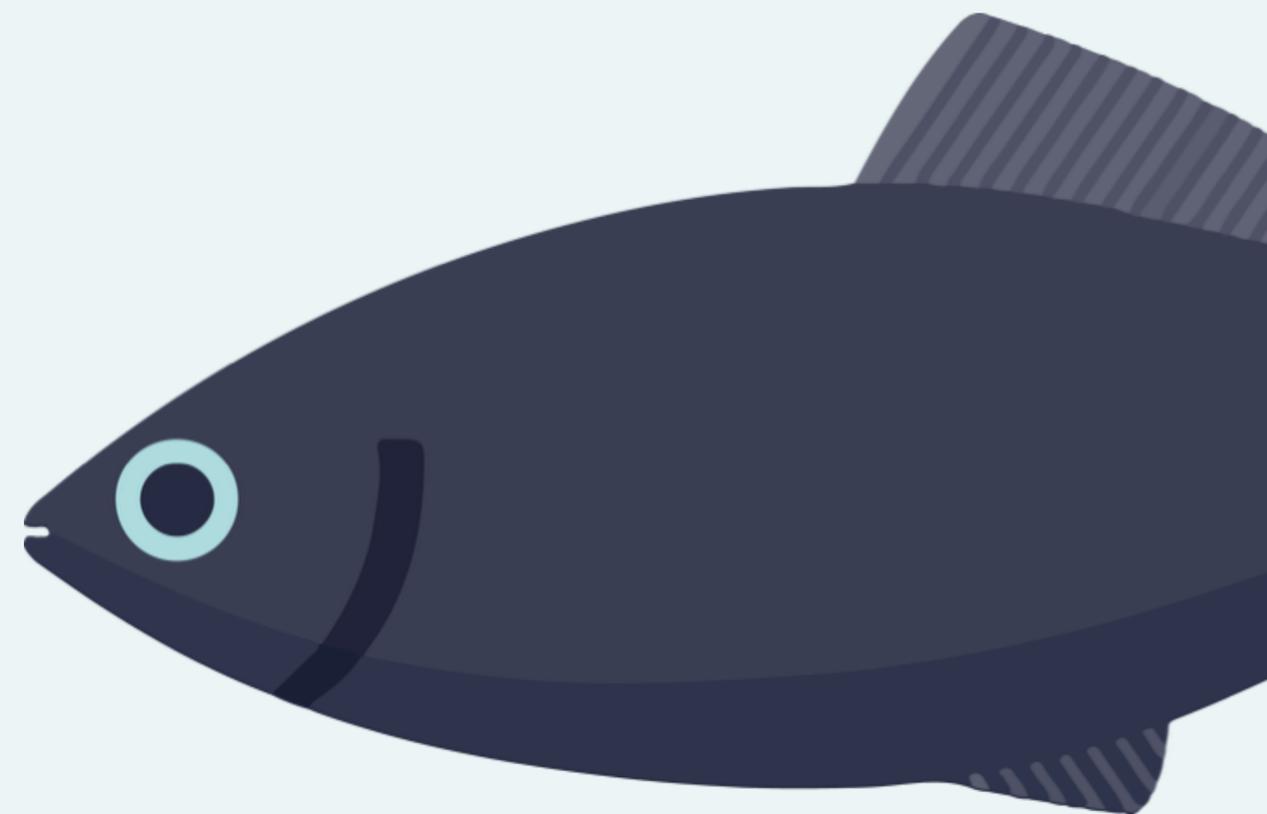
BY 2020:

- **52%** of people living with HIV in sub-Saharan Africa will be living in urban areas.
- **62%** of urban people living with HIV will be living in slums.
- Slums in Nairobi house between **60-70%** of the city's residents.
- Studies show that people living in informal settlements are at greater risk for HIV infection, risky sexual behavior, early childbearing, and other adverse sexual and reproductive health outcomes than those in formal settlements.
- **Increasing urbanization should improve proximity and access to services, but this is not always the case.**



RURAL MIGRATION TREND: 'FISH FOR SEX'

- In Western Kenya, rural beach villages are a key migration destination for women.
- A growing trend among widowed female migrants revolves around the fish trade which is considered “good business” requiring minimal training and start-up costs.



For example, migration to the beaches along Lake Victoria is especially attractive to women recently widowed or fleeing other forms of strife because of the sexual economy that is associated with fisherman. “Fish-for-sex” (the *Jaboya* system) is a system whereby fisherman grant preferential access to female fish traders whom they select as “customers” in exchange for sex.

MUSIC: KEY COMPONENT OF KENYAN LIFE

Kenya is home to a diverse range of music styles, ranging from imported popular music, afro-fusion and benga music to traditional folk songs



THE EVOLUTION: WESTERN BEATS WITH LOCAL



- In the recent past, newer varieties of modern popular music have arisen which are mostly local derivatives of western hip-hop. Two sub genres have emerged: **“Genge”** and **“Kapuka”** beats. This has revolutionized popular Kenyan music and created an industry dominated by the youth.
- There is also underground Kenyan hip hop that gets less radio play than Kapuka or Genge because it is less club-oriented and more focused on social commentary.
- Celebrities in this space include: Jaguar, Nameless, Redsun, Nyashinski and a popular celebrated Kenyan boy band, Sauti Sol.

GOSPEL MUSIC HAS GONE MAINSTREAM

- Ambiguous lyrics that can be interpreted as referring either to spiritual or physical love have helped drive the mainstream appeal of urban gospel in Kenya.
- From presidential inaugurations to nightclubs, urban gospel is present not just at the periphery, but is now a central attraction.
- “It is a multi-million shilling industry spinning off corporate sponsorship and endorsement from the state.” This position at the centre of mainstream popular culture can perhaps best be illustrated by condom brand 69 [approaching popular gospel artist Hey Z](#) to be its brand ambassador.

<http://thisisafrica.me/lifestyle/true-believers-gospel-fakes/>



A stylized illustration of a red apple with a single green leaf, positioned on the left side of the page. The apple is composed of several overlapping red shapes, and the leaf is a solid green shape. The background is a solid teal color.

THE RISE OF HEALTHY

AWARENESS OF HEALTHY LIVING IS ON THE RISE

Kenyans are regularly informed of the benefits of good nutrition and how it helps avoid prevent undernourishment and weight gain. The mass media, religious organizations, non-governmental organizations and the Government provide health education.

As a result, most Kenyans have broadened their diet and moved away from eating too much nyama choma. They are eating healthier substitutes, such as soya, mushrooms and vegetables. They've also been trying to avoid sugary white loaves of bread and genetically-modified (GM) foods.

There is also a growing perception that naturally-grown foods are beneficial and can prevent diabetes, high-blood pressure and cancer.

Consequently, Kenyans value natural foods and are breaking away from the habit of consuming fatty foods and snacking. There is a perception that a vegetarian diet, not eating animal-based foods, except eggs, dairy products and honey, prolongs life expectancy. More people are adopting this diet in order to manage body weight and improve health.

According to Kenya Organic Agriculture Network (KOAN), demand for organic foods has grown steadily in Kenya. This is driven by the fear of becoming diabetic/obese or developing any forms of cancer.



ATTITUDES TOWARDS PERSONAL CARE

DENTAL CARE:

Most Kenyans are very careful about oral care. Poor households use traditional oral care methods, like chewing special herbs and bark from trees and shrubs. Some of these herbs are found in rural markets and some are sold informally by hawkers in urban centres. People in typical middle-income households prefer using toothpaste and brush their teeth after every meal. They also make occasional visits to the dentist. Rich households use a variety of dental products. They purchase toothpaste, orthodontic braces and tooth-whitening products. They also make regular visits to dentists and hospitals.



SKIN, HAIR, NAIL CARE:

Some people pamper themselves with multi-functional products that contain natural and healthful ingredients like vitamins, minerals, fruits and herbs. On the other hand, poor households opt for jelly; some even use cream from milk. For poor Kenyans, skin care products are a luxury. However, whether people are poor or rich, their choice of skin care products is influenced by their culture.

The middle class and the rich can afford toilet soap. They prefer branded products that have a medicinal function, such as protection against germs.

The Daily Nation confirmed that women use supplements for their skin, hair and, occasionally, nails. Experts, women and metrosexual males think highly of supplements that contain probiotics, fibre, omega 3, calcium and vitamin D.

KNOWLEDGE GAPS: CULTURE

- To what extent are the "healthy living" and personal care trends influencing our audiences? If they are, can we tap into any relevant behaviors to help us communicate PrEP in an unique and compelling way?
- Explore how and to what extent gospel music can help us connect with our audiences, specifically serodiscordant couples.

CONSUMER

Our foundational understanding of consumers, beyond demographics, and including attitudes, beliefs, knowledge and behaviors.

TEGORY

CULTURE

PERCENTAGE CONTRIBUTION TO NEW HIV INFECTIONS (2014):



1. SERODISCORDANT COUPLES 44.1%



4. FEMALE SEX WORKERS 14.1%



2. ADOLESCENT GIRLS AND YOUNG WOMEN 21%



5. PEOPLE WHO INJECT DRUGS 3.8%



3. MEN WHO HAVE SEX WITH MEN 15.2%



6. HEALTHCARE PROFESSIONALS



SERODISCORDANT COUPLES

“Every serodiscordant couple has their own story, it could be that they were married before they found out that one person was positive. (Or) they’ll find out that one partner is positive because maybe the one gets sick and through the healthcare system they both end up getting tested or they have a child who dies and both get tested... every story is different.”

–Stakeholder Interview, Mercy Kamau, Jilinde

WHO ARE THEY?

Estimated to total between **260,000–350,000 couples** (approx. 190,000 uninfected women and 160,000 uninfected men) (2009 Kenya Modes of Transmission Report)

Given their population size and new infection rate, this audience could potentially be our “low hanging fruit,” or door to the other audiences in terms of avoiding the risk of further stigmatizing AGYW, FSW, MSM and PWID through the use of PrEP.

WATCH-OUT:

PARTNERS GENERALLY DON'T KNOW EACH OTHER'S STATUS

Most HIV-positive married or cohabiting couples do not know their partner's HIV status (Kaiser et al.)

When they do test for HIV, it can take time (days to years) to disclose their HIV-1 seropositive results to their sexual partners.*

This is especially true if the wife is likely to experience intimate partner violence as a result of getting tested without her husband's permission. This can potentially be mitigated with counseling and/or psychosocial support, delivered either individually or jointly.**

HIV STATS

- About **11% of couples** in Kenya are living with HIV
- Among married individuals who are HIV-infected, **45%** have a partner who is not currently infected (HIV Prevention Response and Modes of Transmission Analysis Report, 2009)
- **5.9%** prevalence rate (as of 2015)
- **44.1%** of new adult infections every year
- Unknown level of access to “targeted intervention services”

* A Qualitative Study of Barriers to Consistent Condom Use among HIV-1 Serodiscordant Couples in Kenya Kenneth Ngunjiri, et al. *Aids Care*, 2014

** The risks of partner violence following HIV status disclosure, and health service responses: narratives of women attending reproductive health services in Kenya. M Colombini. *JAIS* 2016

SERODISCORDANT COUPLES THEMES

THE 'DISCORDANCE DILEMMA'

INCONSISTENT CONDOM USE

THE IMPORTANCE OF RELATIONSHIP DYNAMICS

COMPROMISED HEALTHCARE

THE 'DISCORDANCE DILEMMA'

"I feel stuck. I love my wife. I want to have sex. I don't like condoms. I don't want to get infected, either... It's not easy. It's difficult. It's a dilemma."



FACING A UNIQUE SET OF CHALLENGES

- Disagreements over sex and procreation
- Blame around bringing HIV into the family
- Psychological stress due to inadequate social support
 - Widely believed that serodiscordant couples “should not give birth to children” because the partner and offspring are inherently infected with HIV
- Can be forced by the church to take an HIV test before getting married (strictly adhered to by Pentecostal and Evangelical churches)
- In one study in the Rift Valley, Kenya, HIV-positive women reported fearing that if their status was seen as indicative of infidelity, their children could be disinherited (Were E et al/2008)

Ultimately, serodiscordant couples may feel that the discordance makes their relationship impossible. (Mack et al./2014)

DESPITE ALL OF THESE CHALLENGES, THE RATE OF SEPARATION REMAINS SURPRISINGLY LOW

Marriage is culturally valued, socially expected and considered a permanently binding commitment. Divorce is discouraged by local Christian churches. Once married, a move to separate by either partner will likely meet with objections from family and friends, who may intercede to try to keep the couple together.

“They have children and assets together, so it [may be] more difficult to separate.”

- Stakeholder Interview, Mercy Kamau, Jilinde

“Divorce is not widely accepted.”

- Stakeholder Interview, Connie Celum, Researcher

INCONSISTENT CONDOM USE

It has been widely assumed that couples educated about condoms as a prevention strategy would motivate couples to use them.

But formidable challenges overshadow consistent and correct condom use.



1. THE DESIRE TO BEAR CHILDREN NO MATTER WHAT

In one study, although most of the couples were aware of the risk of horizontal and vertical HIV transmission, almost all couples reported that they had intended to become pregnant and that the desire for children superseded HIV risk considerations.

Motivations for pregnancy are numerous and complex: satisfying desired family size, desire for biological children, maintaining stability of the union, and sociocultural pressures.

2. MISCONCEPTIONS ABOUT HIV & HOW IT'S TRANSMITTED

- **FATALISTIC:** HIV transmission is based on luck (“my luck can end at any time;)* Act of God or belief in protection by God*
- **DON'T UNDERSTAND HOW HIV IS TRANSMITTED:** Belief that they are immune;** Negative partner is in the ‘window period’;* Transmission is a consequence of ‘rough sex’ and ‘gentle sex’ will protect HIV-negative partners;* Putting on the condom just before ejaculation is enough protection; ** Using substances like bleach or hot water and soap to clean themselves in the hopes of preventing HIV-1 acquisition when the condom bursts**
- **DISTRUST OF THE TEST:**
Hidden infection not detectable by HIV tests*



* *Challenges Facing HIV Discordant Couples in Kenya. International Journal of Business and Social Science Vol. 5, No. 10(1); September 2014*

** *A Qualitative Study of Barriers to Consistent Condom Use among HIV-1 Serodiscordant Couples in Kenya Kenneth Ngunjiri, a, b, * Nelly Mugo, a, c, Connie Celum, c, d, e, Jared M. Baeten, c, d, e, Martina Morris, f, g, Owuor Olungah, h, Joyce Olenja, i, Harrison Tamooah, a and Bettina Shell-Duncan J, Aids Care, 2014*

3. THE RELUCTANCE TO WEAR A CONDOM

One of the main reasons for a male partner's reluctance to use condoms is reduced sexual pleasure. His wife/partner doesn't necessarily have the power to negotiate it because she may have:

- **FEAR OF CONFLICT:** Even suggesting condom use as part of one trial's risk reduction counselling prompted conflict about fidelity and trust.
- **FEAR OF ABUSE:** Requesting male partners to use condoms can spark anger that leads to verbal abuse, withholding of economic support, and in extreme cases, physical abuse.
- **FEAR OF ABANDONMENT:** Women can also fear that their male partners will go out to seek new partners so that they can have sex without a condom.

“You have big children, and you spread a sack for the child to lay down there, and you are with your husband. You will not scream because your husband has not put on a condom. You will be forced to give him sex because you fear the embarrassment with the children being around (F+).”*

But even if these fears didn't exist, her living conditions may not be conducive to arguments about condom use: Women can be forced to accept sex without a condom to avoid waking up their children and neighbors.



4. ALCOHOL GETS IN THE WAY

Alcohol use is a common cause of men's inconsistent condom use.

A Qualitative Study of Barriers to Consistent Condom Use among HIV-1 Serodiscordant Couples in Kenya Kenneth Ngunjiri, et al. Aids Care, 2014

5. GENERAL LACK OF KNOWLEDGE ABOUT HOW TO USE CONDOMS CORRECTLY

In one study,* women reported frequent condom breakages ('bursts') as a normal occurrence (making them feel that they had little control over their risk of acquiring HIV).

However, sometimes condom breakages also result from practices like wiping lubricant from condoms before sex.



* A Qualitative Study of Barriers to Consistent Condom Use among HIV-1 Serodiscordant Couples in Kenya Kenneth Ngunjiri, et al. *Aids Care*

THE IMPORTANCE OF RELATIONSHIP DYNAMICS



WHO WEARS THE PANTS WITH REGARDS TO HEALTH, MATTERS

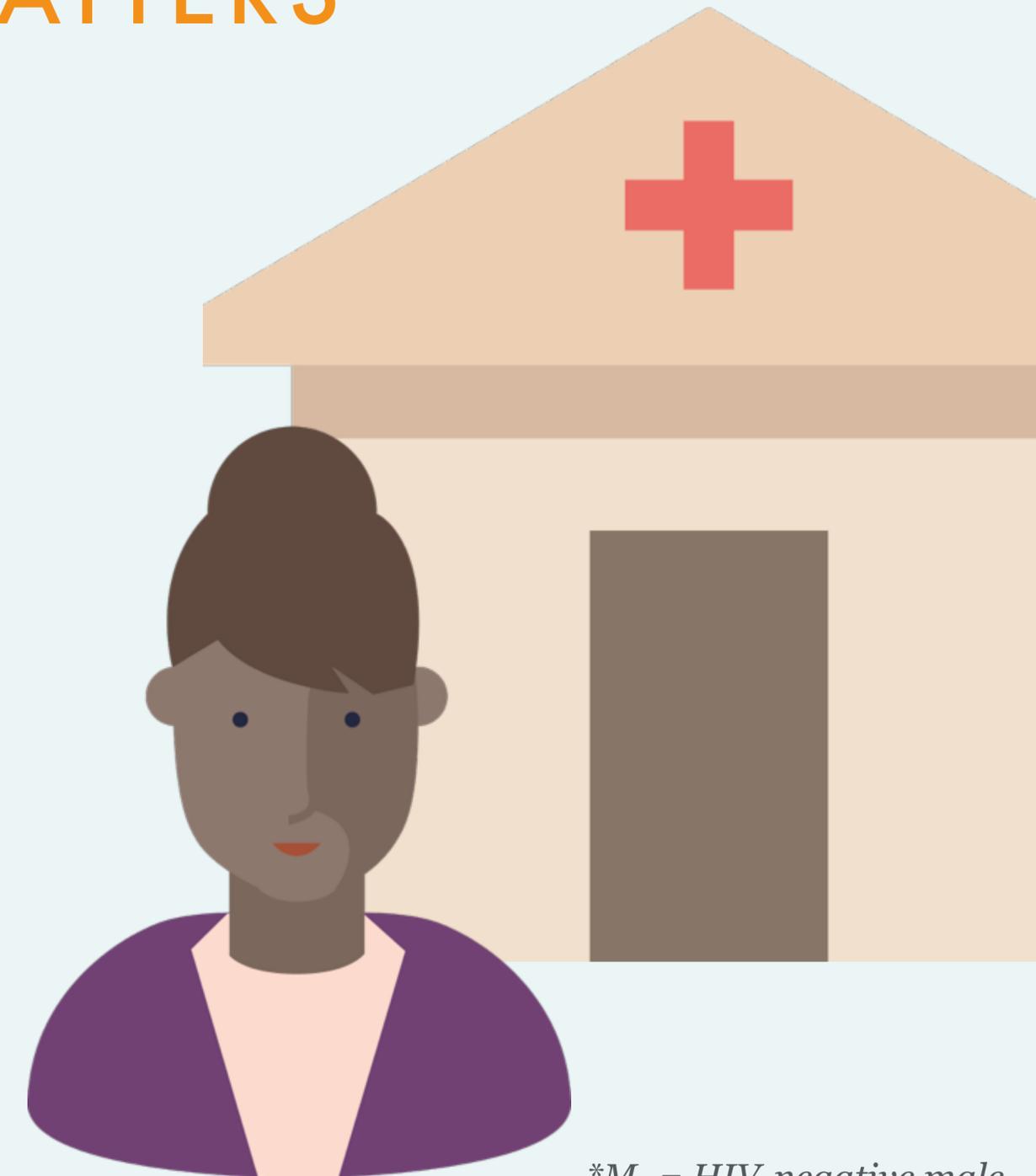
On the one hand, some women/men believe that the decision for either partner to initiate ART or PrEP, as appropriate, belongs with him.

- *“For me, its my husband who decides. (F-)**

However, on the other hand, a cultural belief exists that the health care of the family is the woman’s responsibility.

- *“Normally it is the woman who comes to the clinic” (M-)**
- *“She should take ART in place of me taking [PrEP] because she is the one who has the disease” (M-)*

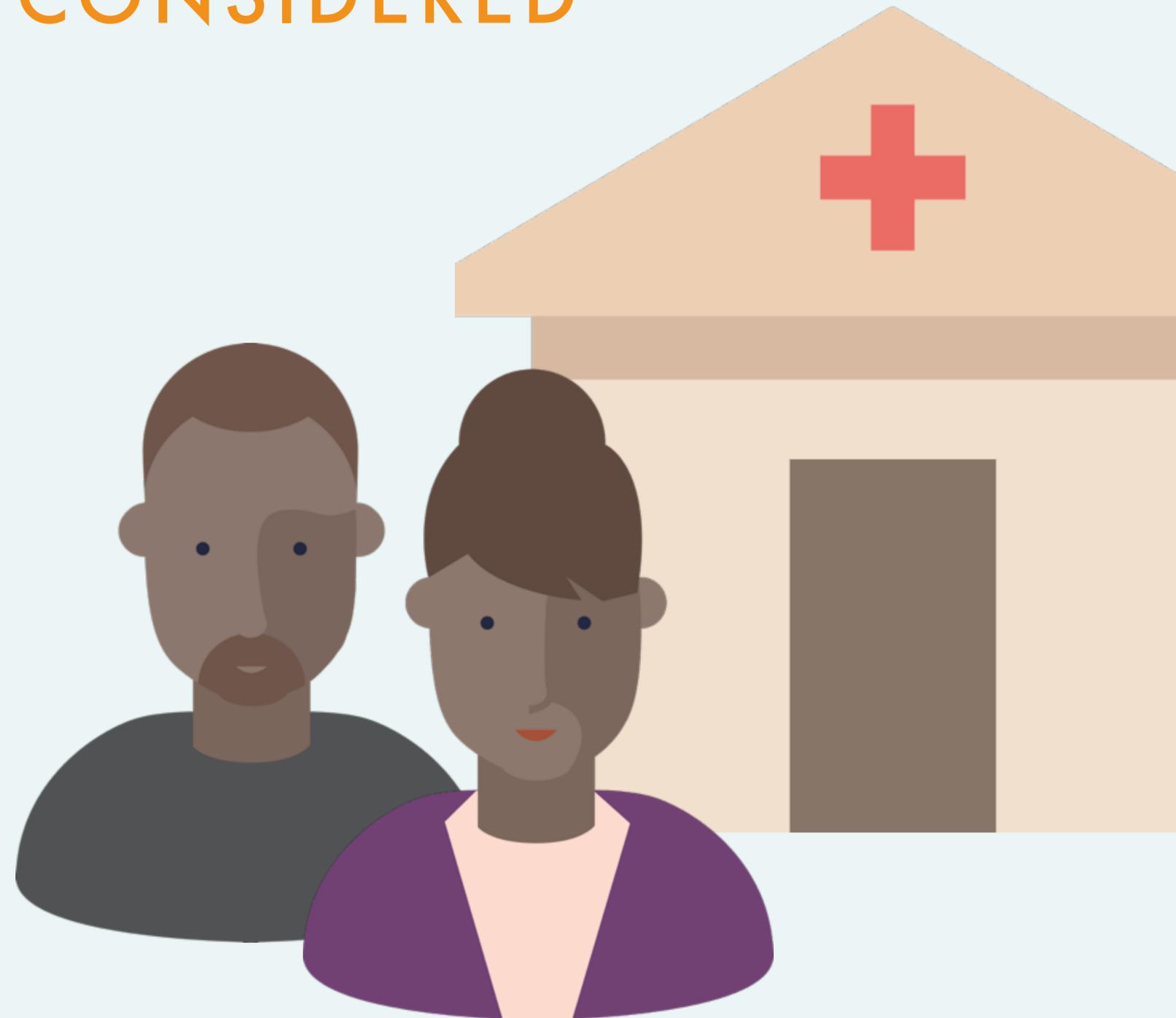
This puts women in the precarious position of being both deferential and proactive.



**M- = HIV-negative male*

HOWEVER, THERE ARE TIMES WHEN HEALTH CAN BE CONSIDERED A JOINT RESPONSIBILITY

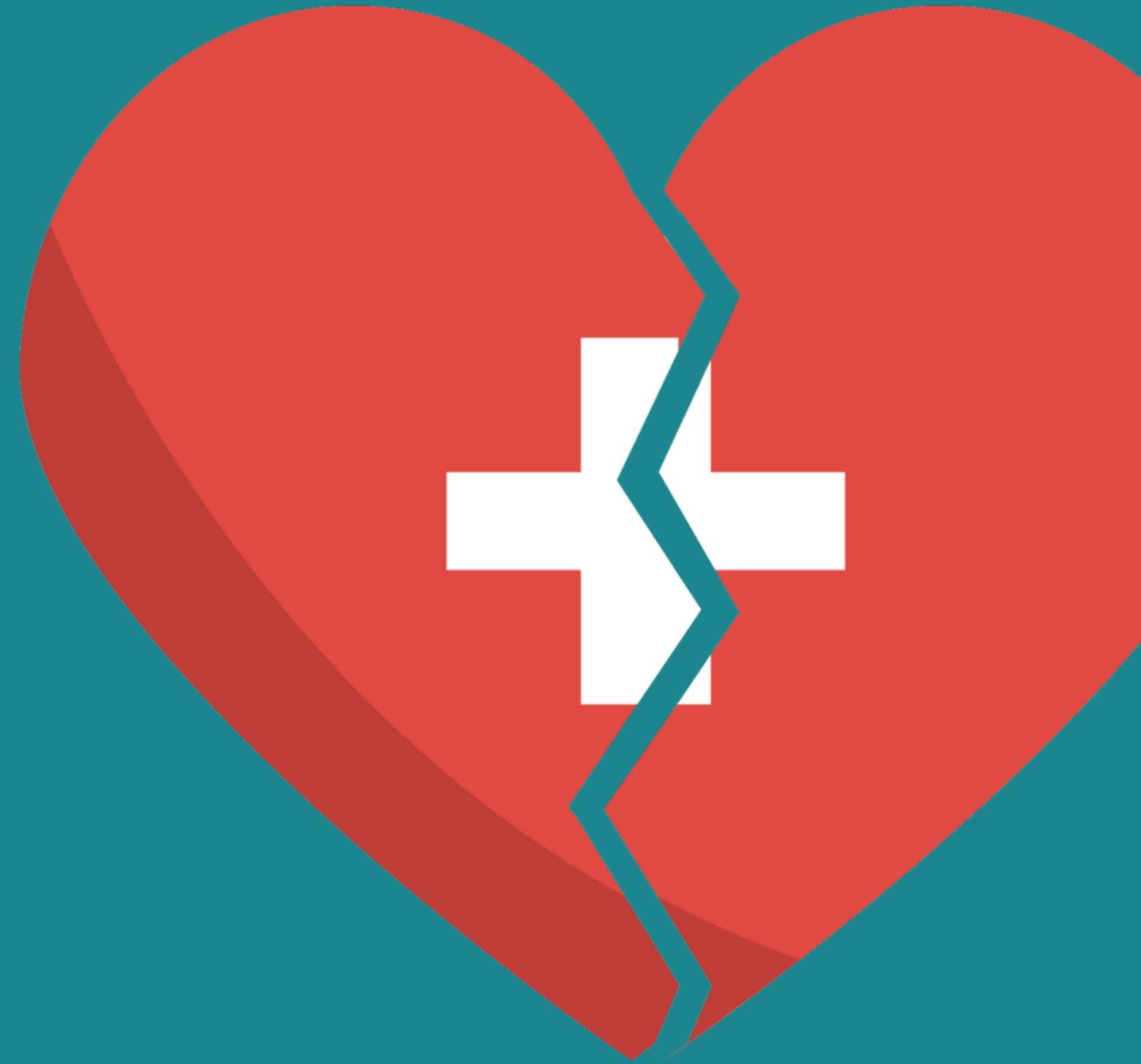
- Qualitative research has found that couples whose relationships are characterized by healthy communication and honesty are more likely to see health as a mutual responsibility, rather than the prerogative of one individual. In fact, honesty and communication has shown to result in an increased uptake of contraception in Kenya, Malawi and Zambia.
- Men who have children with their partners can feel more connected to the relationship, impacting their health-seeking decisions.



Couple interdependence impacts HIV-related health behaviours among pregnant couples in southwestern Kenya: a qualitative analysis Anna Joy Rogers et al. Journal of the International AIDS Society 2016
Gendered differences in the perceived risks and benefits of oral PrEP among HIV-serodiscordant couples in Kenya. Jennifer J. Carroll et al. AIDS CARE, 2016

COMPROMISED HEALTHCARE

HCW attitudes toward HIV-affected couples and their lack of knowledge about safer reproductive methods are barriers to the availability, provision, and uptake of safer conception services sought by HIV-affected couples desiring children



INADEQUATE KNOWLEDGE AND PERSONAL BIASES CAN IMPACT THE KNOWLEDGE SHARED BY HEALTH CARE WORKERS (HCW)

- In one study, HCWs were found to advise HIV-serodiscordant couples to separate because they didn't have the knowledge to support their unique circumstances.
- In another study, HCWs did not share safer conception practices (if not initiated by the client) because they either did not have the knowledge themselves or because they were concerned about what their clients would do with the knowledge before they were virally suppressed/ready to conceive (often based on the misconception that the negative partner was “latently” infected).

RESULT: Serodiscordant couples are reluctant to engage with the healthcare system; preferring to continue to risk HIV transmission in order to conceive.

Barriers and facilitators to pre-exposure prophylaxis (PrEP) eligibility screening and ongoing HIV testing among target populations in Bondo and Rarieda, Kenya: Results of a consultation with community stakeholders. Mack et al. BMC Health Services Research 2014

Perspectives of healthcare providers and HIV-affected individuals and couples during the development of a Safer Conception Counseling Toolkit in Kenya: stigma, fears, and recommendations for the delivery of services, AIDS Care. 2016
"I don't know if this is right ... but this is what I'm offering": healthcare provider knowledge, practice, and attitudes towards safer conception for HIV-affected couples in the context of Southern African guidelines. AIDS Care. 2016;28(3)

KNOWLEDGE GAPS: SERODISCORDANT COUPLES

- What are the general attitudes of the community regarding serodiscordant couples having children - is it viewed negatively or positively? Is it true that attitudes around the belief that HIV+ individuals and couples shouldn't have children is changing within the community?
- Gather further evidence of who this audience goes to for credible information relating to SRH.
- To what extent does this audience engage in routine preventative behaviors (antenatal visits/prenatal vitamins, healthy eating, talismans, protective charms, etc.)? Are there any preventative behaviors that we can tap into when communicating about PrEP?
- What's the extent of the influence that male partners have on our audience when it comes to decisions regarding her/his/the couple's health, and how do they navigate this dynamic?
- How can we best engage men in the PrEP conversation so that their wives/female partners positively perceive PrEP and are able to maintain their adherence if/when they do start on PrEP?
- Further investigate the claim that "clinics are for women." Is this a very prevalent perception that results in men not attending health care clinics? Where, how, when should we reach men if this is the case?
- Will PrEP offer an opportunity for these couples to stay together/resume a normal life? What are some other 'human problems' PrEP can solve for them?



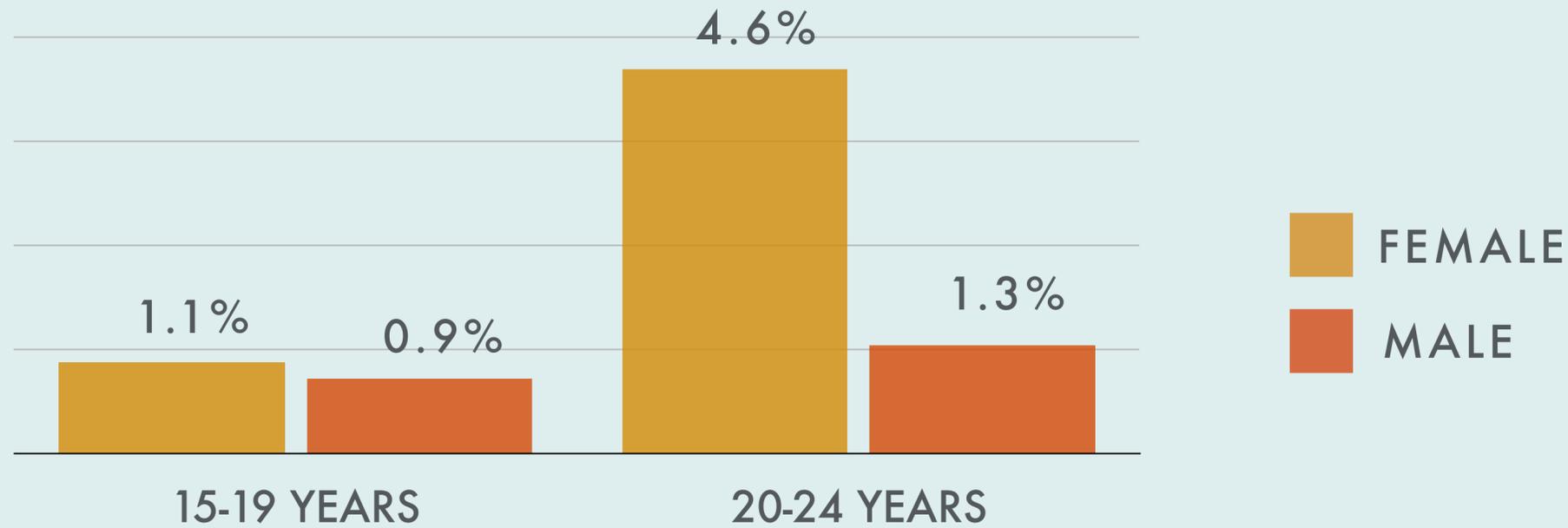
ADOLESCENT GIRLS & YOUNG WOMEN

“I viewed my body through layers of complicated misconceptions that the world told me and which in turn I told myself repeatedly until it became my truth.”

—Aisha, Young Kenyan Woman (awdf.org)

WHO ARE THEY?

Definition: Current data shows adolescent girls and young women (AGYW), defined as those aged 15-24, contributed to 33% of new HIV infections in Kenya (HIV estimates, 2015). This is nearly twice the number than for boys and young men in the same age group.



Among women, HIV increased linearly with increasing age, with the highest increase between the ages of 22 and 23 years. Among men, HIV remained low and stable until 24 years of age.

HIV STATS

- **4.1 million** total AGYW (Ages 15-24) in Kenya, based on 2009 Census
- **21%** of new adult infections per year
- **4.5%** prevalence
- By the age of 24, the rate of infection of AGYW is almost **4 times higher** than young boys
- **90%** of young women test for HIV at least once by the time they are 24 years old

THIS IS NOT A HETEROGENOUS GROUP

URBAN VS. RURAL VS. SLUMS

- Affects their level of access to media and subsequently SRH information: Urban AGYW have a greater chance of owning a mobile phone and/or having access to a TV
- Affects their economic prospects: Approx. 80% of girls living in slums have no income-generating activities
- Affects their opportunity to get a formal education: Girls in poorer and more rural settings have less chance of attending or completing school

LEVEL OF EDUCATION AND WHETHER THEY ARE IN OR OUT OF SCHOOL

Affects their level of income: A typical university student has a low income and is forced to be innovative to survive. For instance, three or four students may live together and share living costs, from furniture, kitchen appliances, electronics to monthly expenses, such as rent and utility bills. The savings generated are spent on learning materials, transport and leisure

“There are different groups within this population and you need different programming for urban women vs. rural women vs. women who are attending tertiary educational institutions.”

—Stakeholder Interview,
Mercy Kamau, Jilinde

SUMMARY: FACTORS INCREASING AGYW'S VULNERABILITY TO HIV

- Orphaned with no parental care
- Living in slums/informal settlements:
Approx. 80% of AGYW living in slums have no income-generating activities (UNESCO)
- Victims of sexual or gender-based violence
- Had an early sexual debut
- Sexually active and engaging in sexually risky behaviors (not using a condom consistently, multiple and concurrent partners)
- Drug/alcohol abuse
- Economically dependent
- Not attending school/have never attended school/have dropped out of school
- “Street-connected”
- Living in a high incidence county: Homa Bay, Kisumu, Kisii, Migori, Mombasa, Nairobi, Siaya, Nyamira, Turkana, Bomet, Nakuru
- Sexually exploited through selling sex
- Members of an ethnic tribe practicing traditions that are known to increase HIV risk (FGM, wife inheritance, sexual cleansing etc.)
- Married to a man who practices polygamy, or to an older man
- Party to an intergenerational relationship (10 or more years her senior)

“Married adolescents are at risk of HIV infection because many of them are not only naïve but face sexual violence... many are in polygamous unions...are never able to negotiate safe sex, because they don't have the skills to do it and... are married to people who are much older than they are, which prohibits partner communication.”
–Pamela Odolo, APHIA II

ADOLESCENT GIRLS & YOUNG WOMEN THEMES

LIMITED PERSONAL AGENCY

CULTURAL AND SOCIAL NORMS MAGNIFY HER VULNERABILITY

CONFLICTING MESSAGES FROM INFLUENCERS

MISINFORMED AND UNINFORMED OF HER RISK

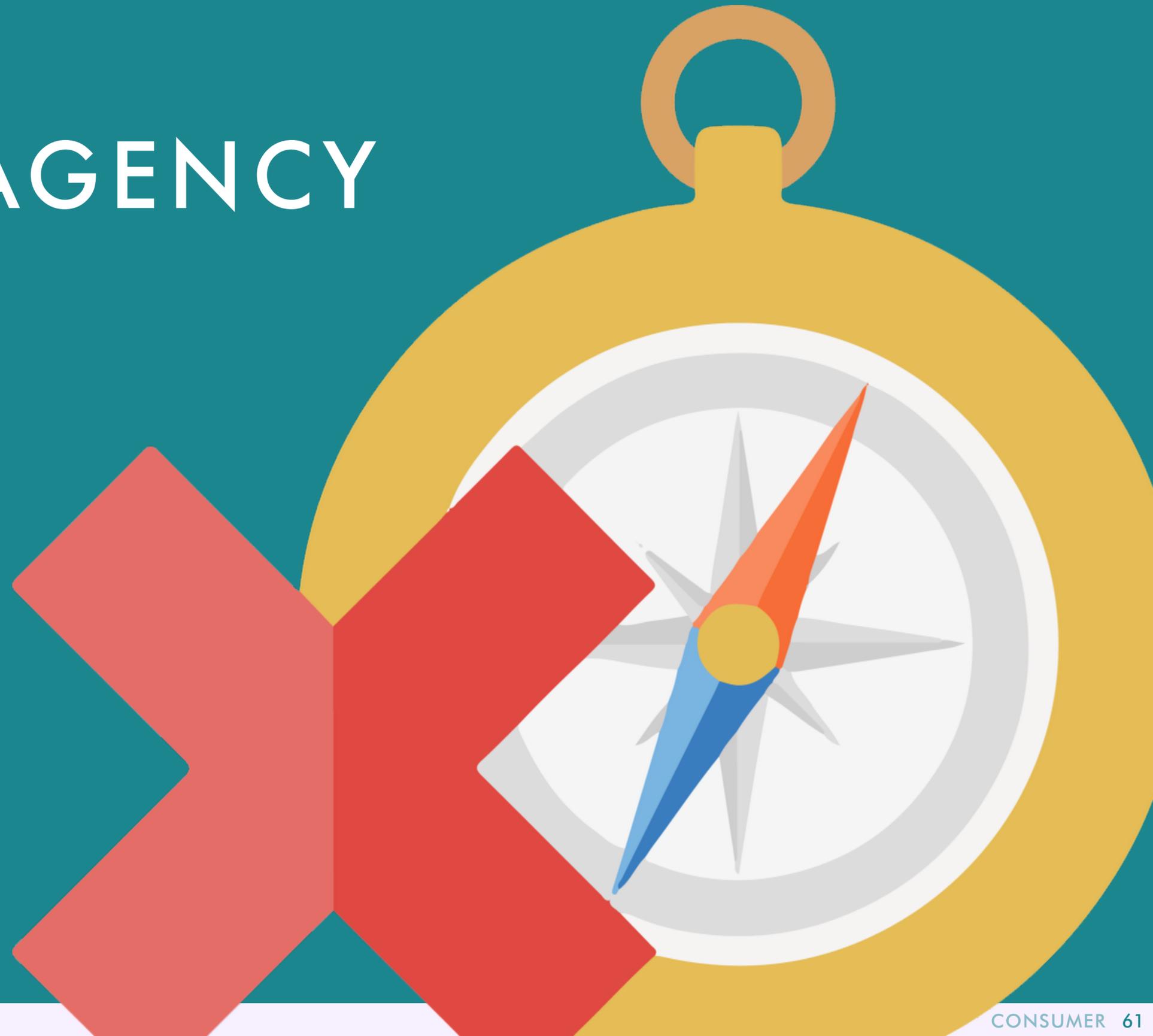
MORE CONCERNED WITH UNINTENDED PREGNANCY

LIMITED ACCESS TO HEALTHCARE

HIV INITIATIVES FOR ADOLESCENTS ARE DRIVING CHANGE

LIMITED PERSONAL AGENCY

Without an education, or the healthy flow of information relating to sexual and reproductive health matters, her level of control over the direction of her life can suffer greatly



SEXUAL AND REPRODUCTIVE HEALTH INFORMATION

- **20%** of adolescent girls never attend school at all, while only **57%** complete primary education

TEACHING YOUNG PEOPLE ABOUT HIV AND SEXUAL HEALTH REMAINS CONTROVERSIAL

- HIV/AIDS is part of the curriculum but condom use is not
- One-third of Kenyans believe that teaching about contraception is immoral

SEX IS TABOO FOR BOTH PARENTS AND TEACHERS

“Teachers cannot teach about SRH themselves because they are also not comfortable, they are parents themselves.”

– Stakeholder Interview, Mercy Kamau, Jilinde

“You do not talk about these things with parents. It is just not done.”

– Stakeholder Interview, Mercy Kamau, Jilinde

WITH A LACK OF PERSONAL AGENCY, EVERYTHING HAPPENS SOONER

She has sex sooner.

YOUNG AGE OF SEXUAL DEBUT

1 of every 5 youths aged **15-24** reported having sex before their **15th** birthday (Adolescent, Youth and HIV in Kenya Fact Sheet, 2014)

By age 18, nearly half (**47 percent**) of women have had sexual intercourse (Kenya MOT Analysis Report, 2009)

She gets married sooner.

MARRIED AT YOUNG AGE

The median age at first marriage among women age **25-49** is **20.2** years (Kenya Demographic and Health Survey, 2014)

She has children sooner.

CHILDBEARING AT YOUNG AGE

Almost one-quarter of women giving birth by age **18** and nearly half by age **20** (Kenya Health and Demographic Survey, 2014)

CULTURAL AND
SOCIAL NORMS
MAGNIFY HER
VULNERABILITY





KENYA'S PATRIARCHAL SOCIETY HAS FAR-REACHING CONSEQUENCES FOR HER SEXUAL AND REPRODUCTIVE HEALTH

NO POWER TO NEGOTIATE CONDOM USE

28% of men aged 15 to 49 years believe that a woman has no right to request that a man use a condom

SUBJECT TO SEXUAL VIOLENCE

- Young women in Kenya are over three times more likely to be exposed to sexual violence than young men.
- About **33%** of girls in Kenya are raped by the time they attain 18 years; **22%** of girls aged 15-19 report that their first sexual intercourse was forced.

Exposure to violence during childhood and adolescence increases HIV-related risk behavior among adolescent girls and young women.

INTIMATE PARTNER VIOLENCE (IPV) INCREASES SUSCEPTIBILITY OF HIV RISK

- **47%** of ever-married women (15-49) have experienced intimate partner violence
- Intimate partner violence is viewed by some as a normal, timeless tradition:

“A woman must be beaten somehow, because it is a practice that has been there even before we were born.”
–Esther, 31

SOME OF THE TRIGGERS FOR IPV INCLUDE:

- Failure to consult husband on health-related decisions, like HIV-testing
- Perceived relationship infidelity
- Transgressing gender norms

*In some regions, women who are exposed to intimate partner violence are **50%** more likely to acquire HIV than women who are not exposed.*

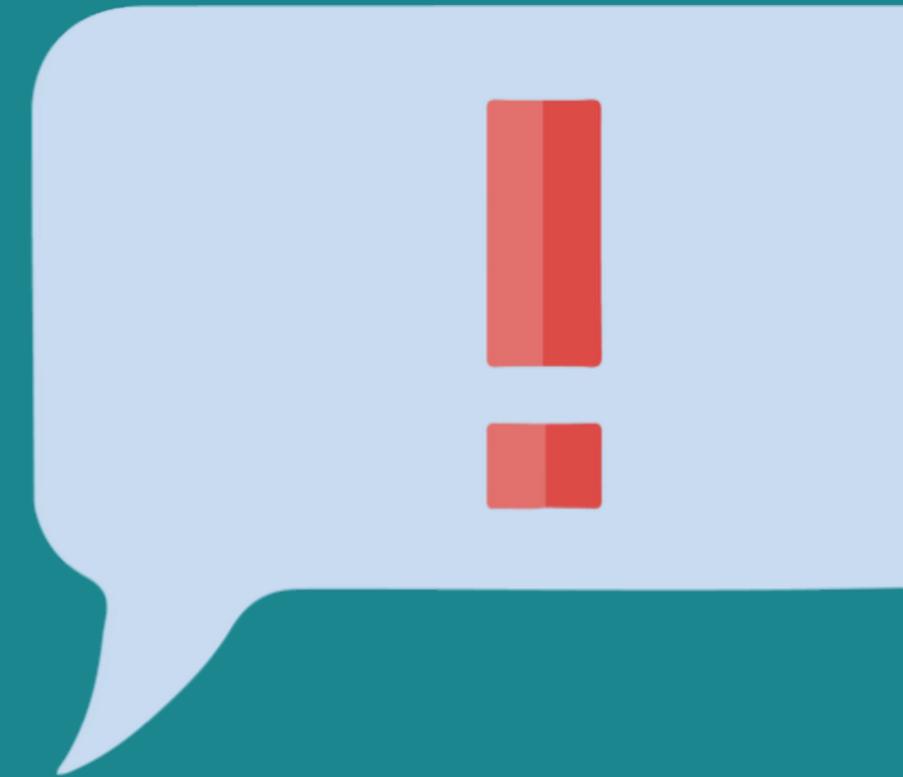
“Some say that it is what entails marriage. Some people say that is how people live.” –Pauline, 23

Central Bureau of Statistics, 2010

Social context and drivers of intimate partner violence in rural Kenya: Implications for the health of pregnant women. A Hatcher et al. *Cult Health Sex*. 2013.

Get on the fast track. *The Lifecycle approach to HIV*. UNAIDS 2016

CONFLICTING MESSAGES



SHE IS RECEIVING CONFLICTING MESSAGES FROM VARIOUS SOURCES

“Sex is cool. There’s a lot of peer pressure.”

– Stakeholder Interview,
Mercy Kamau

FROM HER PEERS

Given her life stage, her behavior is usually driven by peers.

“I think it’s also a lack of role models. Let’s say, like the older people... preach with water and take wine. Meaning that maybe they say that you shall not be promiscuous and they are the first ones to run to those people, to the bar maids.”

–Female Participant*

FROM HER ELDERS

Role models who range from parents and teachers to celebrities influence her behavior. While in some parts of rural Kenya, the influence of aunts and grandmothers is heavy.

FROM THE CHURCH

It’s common for girls to place a high value on abstinence before marriage (given the message received from the church) but it is difficult for that idea to take hold when they are surrounded by biological, peer and social pressures to express their sexuality.

A stylized illustration of a woman's face with dark skin, dark hair, and a slight smile. To the right of her face is a large, bold red question mark. The background is a solid teal color.

MISINFORMED AND UNINFORMED OF HER RISK

Similarly without an education, or the flow of accurate information related to sexual and reproductive health matters, she is unable to make informed choices.



DOESN'T KNOW HER HIV STATUS

Only **23.5%** of adolescents aged 15-19 years know their HIV status. Among those aged 15-19 only about half have ever tested for HIV.

CAN'T IDENTIFY WAYS OF HIV TRANSMISSION

Only **54%** of young women can correctly identify ways of preventing sexual transmission of HIV compared to **64%** of young men. (2014 Demographic Health Survey)

HER WORLD IS RIFE WITH MISCONCEPTIONS

*Having sex with a virgin will cure you of the HIV virus**

*If you wash your vagina with coca cola after having sex “everything will come out” i.e. you will not become HIV infected**

*Sex during ovulation is better because there is less risk of transmitting HIV (because the vagina is more wet)**

*Condoms are spreading HIV/AIDS**

*If you have sex standing up, you will not fall pregnant**

*Boys have “safe days” when they cannot make a girl pregnant**

* Ecological factors influencing HIV sexual risk and resilience among young people in rural Kenya: implications for prevention. HEALTH EDUCATION RESEARCH Vol.29 no.1 2014

SHE UNDERESTIMATES HER RISK OF CONTRACTING HIV



INCONSISTENT CONDOMS USE

Two-thirds of girls aged 15-24 use a condom at first sex but study findings show that as sexual relationships build and the issue of trust sets in, more women aged 15-24 years are reported to abandon use of condoms with partners of unknown status (**89%**).*

*Get on the fast track. The Lifecycle approach to HIV. UNAIDS 2016.
* LVCT Health.org; Young people's perception of sexual and reproductive health services in Kenya; Pamela M Godia, Joyce M Olenja, Jan J Hofman and Nynke van den Broek. BMC Health Services Research 2014
Stakeholder Interview with Mercy Kamau
** End-User Research Landscape Mapping, HIV PMM < AVAC, Published Jan 2017*

HIGH-RISK SEXUAL BEHAVIOR

The LVCT Health PrEP Demo Project** found 3 groups of AGYM as it related to their risk perception:

1. Those who very clearly understand their risk and are early PrEP adopters
2. Those who know their risk and need counselling and information on PrEP
3. Those who absolutely do not perceive their risk and do not think they need PrEP

Groups 1 and 2 could potentially be our low-hanging fruit in terms of communicating to this audience.

*“All White Parties where as many as 20 students come together, and it's a free for all. Everyone has sexual relations with everyone, could be for the whole weekend. No rules. Lots of drinking and drugs. Anyone for everyone.”
– Stakeholder Interview, Mercy Kamau, Jilinde*

TRANSACTIONAL SEX

- An estimated **16%** of girls aged 15-19 (according to the 2003 Kenya DHS study) engaged in transactional sex.

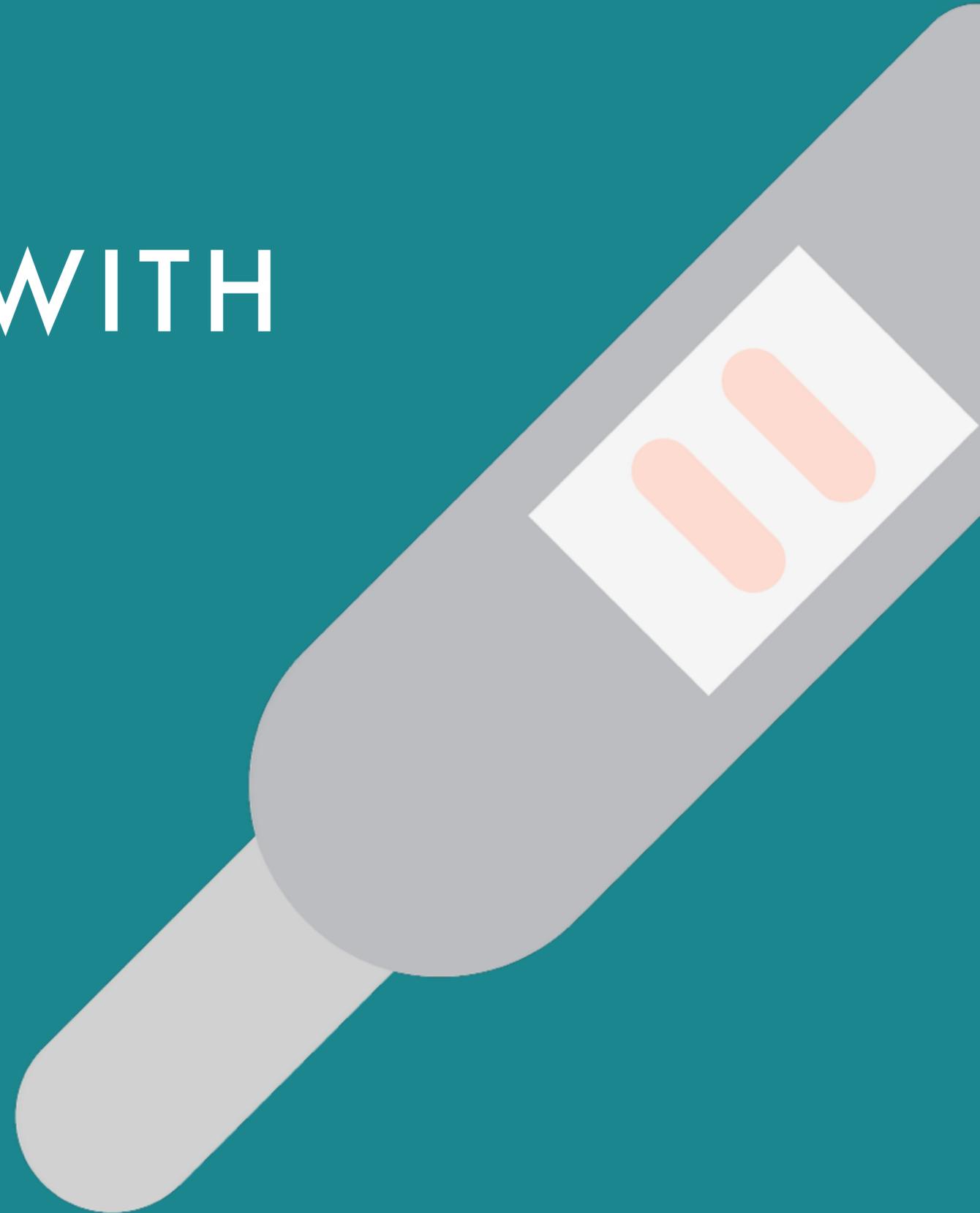
“Young women and adolescent girls reported having sex because they wanted chips (French fries) or because they wanted someone to give them a ride. They said that they had sex for money and for prayers, which they hoped would help them to pass exams.” (AVAC)

INTERGENERATIONAL RELATIONSHIPS & SPONSOR CULTURE

- The ‘sponsor’ trend, where older men / sugar daddies support girls and young women’s lavish lifestyles in exchange for sex, may be contributing to high HIV infection among the youth
- This is potentially a growing trend in urban centers
- Pressure to engage in intergenerational relationships can also come from parents

“Having a sponsor for university girls is “the talk of the day...if you don’t have a sponsor you are outdated.”
– Stakeholder Interview,
Mercy Kamau, Jilinde

MORE CONCERNED WITH UNINTENDED PREGNANCY



THESE GIRLS AND WOMEN WORRY ABOUT PREGNANCY, POTENTIALLY EVEN MORE THAN THEY EVER WORRY ABOUT HIV**

“If you visit a pharmacy during school holidays, the drug Postinor 2 experiences high sales.”

– Stakeholder Interview, Lucy Ghati, Kelin Kenya

“HIV is not a big issue. The biggest issue is pregnancy. HIV is number 2.”

– Stakeholder Interview, Daniel Were, Jhpiego

The 2008–09 Kenya Demographic and Health Survey estimates that 43% of pregnancies in the country are unwanted or mistimed

“WHY AM I LEFT TO FEND FOR MYSELF IF I FALL PREGNANT?”

Girls face health and social consequences while the male partners tend to deny responsibility*

In the FGDs with girls from Nairobi, there were concerns about boys “denying” or “disowning” girls they made pregnant by refusing to take responsibility. This was reaffirmed by boys who stated that denial of responsibility happened if the pregnancy occurred “accidentally”, “unplanned”, “unexpectedly” or by “bad luck” and the boy had no means of supporting both the child and the girl financially**

* “The Attitudes of Kenyan In-School Adolescents Toward Sexual Autonomy” African Journal of Reproductive Health Mar 2010

** Young people’s perception of sexual and reproductive health services in Kenya; Pamela M Godia, Joyce M Olenja, Jan J Hofman and Nynke van den Broek. BMC Health Services Research 2014

LIMITED ACCESS TO HEALTHCARE



THE HEALTH CARE SYSTEM CAN BE INACCESSIBLE AND UNAPPROACHABLE

LACK OF CONFIDENTIALITY

- *“Girls/boys can’t enter and get condoms for example without their neighbors seeing them and reporting them to their parents. This is important to youth”*
—Interview with Mercy Kamau, Jilinde

LACK OF YOUTH FRIENDLY* SERVICES

- Judgmental or negative attitudes of HCW’s
- Long queues
- Current estimates show that only **7%** of facilities are able to provide youth friendly HIV counselling and testing services

DIFFICULTY ACCESSING SERVICE

- No means to travel
- No permission to travel

* A 2013 review done by Ambresin et al., identified 8 domains critical to young persons’ positive experiences of care were identified: “accessibility of health care; staff attitude; communication; medical competency; guideline-driven care; age appropriate environments; youth involvement in health care; and health outcomes.”

Kenya Service Provision Assessment Survey 2010: Preliminary Report. 2010, National Coordinating Agency for Population and Development, Ministry of Medical Services, Ministry of Public Health and Sanitation, Kenya National Bureau of Statistics, and ICF Macro)

Young people’s perception of sexual and reproductive health services in Kenya; Pamela M Godia, Joyce M Olenja, Jan J Hofman and Nynke van den Broek. BMC Health Services Research 2014

HIV INITIATIVES FOR ADOLESCENTS ARE DRIVING CHANGE

THERE ARE INITIATIVES TO PULL THESE YOUNG WOMEN FROM THE SITUATIONS THEY FIND THEMSELVES IN

PEPFAR'S DREAMS INITIATIVE

\$385 million partnership to reduce HIV infections among adolescent girls and young women in 10 sub-Saharan African countries, including Kenya.

Combines evidence-based approaches that go beyond the health sector, addressing the structural drivers that directly and indirectly increase girls' HIV risk, including poverty, gender inequality, sexual violence and a lack of education.



GLOBAL ALL-IN CAMPAIGN

Launched by the President Uhuru Kenyatta in 2015 under the Ministry of Health the campaign aimed to achieve reductions in AIDS-related deaths to mobilize adolescents as agents for social change

KNOWLEDGE GAPS: ADOLESCENT GIRLS AND YOUNG WOMEN

- Are AGYW making the connection between gender-based violence and HIV risk?
- How are health workers currently helping girls navigate the sea of misinformation around HIV prevention (if at all)?
- To what extent does this audience engage in routine preventative behaviors (antenatal visits/prenatal vitamins, healthy eating, talismans, protective charms etc.)? And why?
- What is the extent of the influence that male partners have on this audience when it comes to decisions regarding her/his/the couple's health, and how do they navigate this dynamic?
- Further investigate the claim that “clinics are for women” and how we can engage men/male partners within the context of this key population.
- Will PrEP offer an opportunity for these girls to feel more empowered? What will ‘empowerment’ mean for them? What expressions can it take? What are some other ‘emotional problems’ PrEP can solve for them?

MEN WHO HAVE SEX WITH MEN

Homosexuality is "largely considered to be taboo and repugnant to the cultural values and morality" of Kenya. [UN HRC, 103rd Session]



WHO ARE THEY?

Definition: According to UNAIDS, ‘men who have sex with men’ are those males who have sex with other males, regardless of whether they have sex with women or have a personal or social identity associated with that behavior such as being gay, bisexual or transgender.

AGE SEGMENT:

Median age 28 years (IQR 24-35)

GEOGRAPHY:

Mostly urban and some rural

EDUCATION:

80% primary or secondary education, 14% tertiary level

CRIMINALIZED:

Sodomy carries a prison term of up to 14 years

THE LEVEL OF INTERNALIZED STIGMA WILL IMPACT HOW THEY SELF-IDENTIFY:

In other words if they have high levels of internalized stigma, they may identify as “straight” or possibly “bi-sexual.” If not, they may identify as “gay.”

LEAD DOUBLE LIVES:

At least one in every four LGB persons alludes to having a heterosexual relationship to serve as a distraction for family and neighbors.

40% have never been married

PREVALENT RATES OF SEX WORK:

In a study in Mombasa in 2007, nearly three quarters of MSM had reported selling sex for goods/services in the previous 3 months. (Muraguri et al./2015)

Hot spots for sex work are similar to those of FSW: street-based, home-based, road (truck stop)-based, sex den-based, venue-based, escort services, and massage parlour-based.

VARIED ECONOMIC BACKGROUNDS:

Their wealth matters as a “means” to hide their sexuality. Wealthy men can navigate homophobic environments more easily, since they can afford to live and seek healthcare more privately. (Access to HIV Prevention and Treatment for Men Who Have Sex with Men: Findings from the 2012 Global Men’s Health and Rights Study)

Occupation: professionals, unemployed, students

HIV STATS

- Unknown number of MSM in Kenya, however figures range between approximately **18,000 and 35,000**
- **18.2%** prevalence
- **15.2%** of new adult infections every year (includes MSM in prisons)
- **74%** have tested for HIV in the past year and know their status
- **55%** receive “targeted intervention services”

MEN WHO HAVE SEX WITH MEN THEMES

GRADUAL ACCEPTANCE?

SEXUAL EXPRESSION REQUIRES A SPECIAL KIND OF BRAVERY

IN DANGER OF BEING LEFT BEHIND

GRADUAL "ACCEPTANCE"?

In 2007, a Pew Research Study found that 4% of Kenyans said society should accept homosexuality. When researchers repeated the survey in 2013, the percentage had doubled.



IGNORED IN URBAN AREAS VS. STIGMATIZED IN RURAL AREAS

“I wouldn’t use the word ‘acceptance’. A lot of Kenyans (in urban areas at least) don’t see the value in making a big issue of it because it doesn’t impact their life. Stigma and discrimination is far more prevalent in rural areas. Because there is less awareness, lower levels of education and less exposure (to MSM) than there has been in urban areas.”

– Stakeholder Interview, Brian Macharia, GALCK

EXAMPLES OF VARYING LEVELS OF “ACCEPTANCE”

Peter, 19, has not told his family he is gay and has no intention of doing so because homosexuality is “against the rules of the rural community and society at large.”

Daniel, 20, plans to tell his family he is gay because he wants to put an end to the blackmail of his cousin, who has been demanding money and other items in return for his silence. Blackmail against gay men in Kenya is common.

Hasan, 28, told his family of his sexual orientation eight years ago, and his mother and brother support him and told him “to be who you are.” He attends a church that accepts him and at least three other gay men.

These three gay Kenyans are in very different places with regards to their openness of their sexual identities...

**BUT ONE THING THEY ALL DESIRE
IS FREEDOM OF EXPRESSION**

SELF (AND SEXUAL) EXPRESSION REQUIRES A SPECIAL KIND OF BRAVERY

Not only is sex between men criminalized, but stigma and discrimination towards this population is rampant.

ALMOST EVERY CORNER OF SOCIETY DISCRIMINATES AGAINST MSM

HARASSMENT BY STATE OFFICIALS:

- Routinely harassed by the police, held in remand houses beyond the constitutional period without charges being brought against them, and presented in court on trumped-up charges (“planting” rolls of bhang (cannabis sativa) on the suspects)
- Being arrested for the ‘wrong’ offense e.g. the most common being drunk and disorderly and prostitution
- Subject to extortion/blackmail or sexual favors in exchange for their freedom

PHYSICAL VIOLENCE AND THREATS OF DEATH:

- The most reported forms of violence include, but are not limited to, physical violence (harassment, riots, beatings, lynching and mob justice), hateful printed publications (text messages, posters, books, printed and online publications) and hate speech
- *“Pig, they should all be rounded and locked up in an island.....”*
– Businesswoman, Nairobi

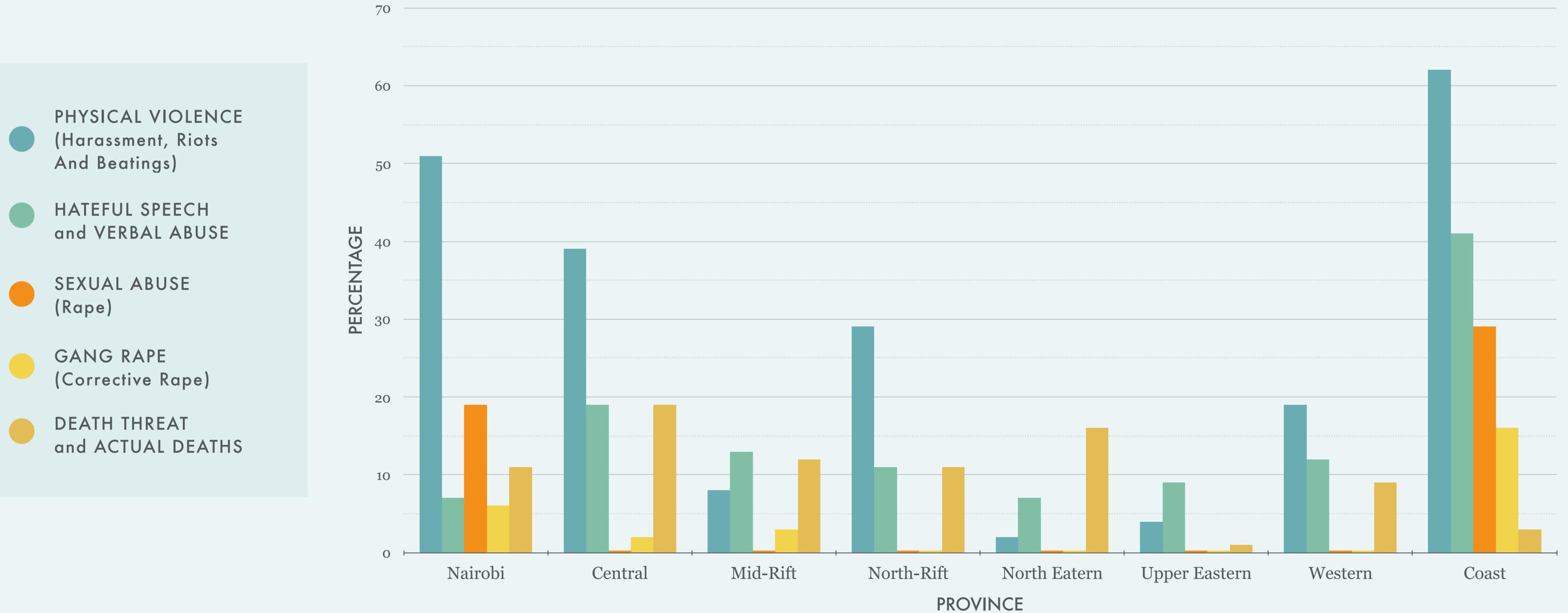
STIGMA BY FAMILY AND THE COMMUNITY:

- Being disowned, forced to attend counseling sessions to get over their “confusion”, fired from work, or subject to humiliation and ridicule
- Secondary to the stigma and discrimination are a chain of associated violations which include aggression and humiliation in public, refusal to get service by service providers such as doctors, landlords, bankers, and lawyers
- Expulsion/suspension from learning institutions

MEDICAL RESEARCH ABUSE:

- Forced HIV testing, forced anal and rectal examination by police, hormonal, shock or
- Psychological therapy and or religious exorcism to correct an LGBTI
- Identity without the consent of the person
- Most therapies are forced by parents or family hoping for curative effects which often fails

LIKELY VICTIMS OF VIOLENCE DEPENDING ON WHERE THEY LIVE



THE OUTLAWED AMONG US. A STUDY OF THE LGBT COMMUNITY'S SEARCH FOR EQUALITY AND NON-DISCRIMINATION IN KENYA, BY THE KENYA HUMAN RIGHTS COMMISSION (2011)

CONSTANT FEAR AND SELF-LOATHING

“How can I see myself as a good person when everyone and everything tells me I am a sinner?”

“Because of my sexual orientation I have always tried to attract as little attention as possible, afraid that people will call me names or, even worse, attack me. This is a characteristic I share with many other LGBTs in my country, Kenya.

Many of us belong to a hidden society that tries to remain as invisible as possible in order to avoid the confrontation of daily abuse, stigma and discrimination.” – MSM

POOR MENTAL HEALTH

- Being forced to hide their sexuality from family, friends, coworkers, and broader society can lead to internalized shame and poor self-worth, often manifesting in depression and anxiety
- Because their mental health may need as much attention as their physical health, healthcare that is comprehensive in terms of addressing the ‘whole human being’ can be a compelling lever
- MSM are also looking for places to socialize, learn, eat, commune and work together (i.e. places where they can express themselves freely)

“Most of us have high levels of depression. We learn to live with it or die.”

COPING STRATEGIES

“I have a wife, I don’t love her because I married her to please my mother, I love my boyfriend most.”

—Bisexual Man**

“We always say ‘security’ starts with you. If you are going out, be very discrete in your dress code. Always have a security code on your phone so that if someone goes through your phone they cannot see porn materials there. Always tell someone where you are going. Always have condoms and lubricant on your person, because you never know.”

—Stakeholder Interview, Brandon Kimani, MSM Peer Educator

Qualitative research in Kenya & Uganda has revealed that men employ various strategies to hide their relations with other men. Some said that they have initiated relationships with women as a disguise, masqueraded as straight men, some mentioned that they changed residence frequently so that people who might harass them would not be able to find them.

HIGH RATES OF DRUG & ALCOHOL ABUSE

Another coping mechanism is using drugs and alcohol.

The fact that alcohol, drug and tobacco use all occur at significantly higher rates in the MSM community than in the general population is one of the most widely acknowledged MSM health concerns.



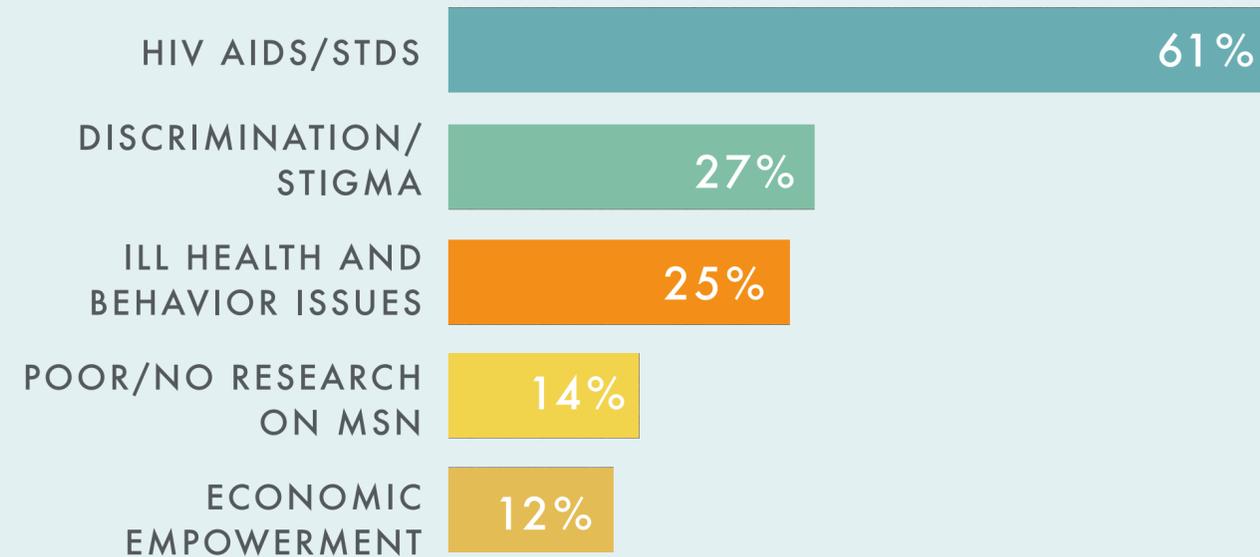
IN DANGER OF BEING LEFT BEHIND

“Health care services are generally not addressed, acceptable, accessible or affordable to the MSM community.”

– Republic of Kenya, Ministry of Public Health, 2010

HIGH LEVELS OF DENIAL AND LOW LEVELS OF KNOWLEDGE PERPETUATE THEIR HIV RISK

While it has been found that **6 out of 10** MSM worry about their risk of contracting HIV, multiple partners and low levels of condom use still remain a problem.



MULTIPLE PARTNERS:

In one study, the prevalence of multiple partners was high. **45%** had multiple partners, **32%** had two and **23%** had one sexual partner in the last six months

LOW LEVELS OF CONDOM USE:

Only **68.8%** of MSM used condoms (2013)*

“There are some that just don’t like condoms and just don’t use them, but for others, condoms and lubricants just aren’t available, so they feel that there are few support mechanisms [to help keep them HIV-free].”

—Stakeholder Interview, Michael Ighodaro, Program and Policy Assistant, AVAC

MISCONCEPTIONS:

Some men believe that anal sex is ‘safer’ than vaginal sex (and are willing to wear a condom for vaginal sex)*

Others believe that only ‘tops’ are at risk and that not having sex with women maintains their virginity, thereby removing their risk of contracting HIV.

National AIDS Control Council of Kenya (2014) 'Kenya AIDS Response Progress Report 2014: Progress towards Zero'

* Social context, sexual risk perceptions and stigma: HIV vulnerability among male sex workers in Mombasa, Kenya, Jerry Okal et al. Culture, Health & Sexuality Vol. 11, Iss. 8, 2009

Stakeholder Interview, Brandon Kimani, MSM Peer Educator

RELUCTANT TO SEEK HEALTH CARE AND REVEAL THEIR SEXUALITY

- Health seeking behavior for STI symptoms frequently involves delay and concealment. (Population Council, 2008)
- Avoiding HCWs can lead to risky choices such as seeking out unqualified care and self-medicating.
- In one qualitative study nearly two-thirds of respondents in Kisumu reported having some discomfort when seeking health services at a public hospital directly related to the fear that people would stare at them. Similar findings have been reported in South Africa and Malawi.
- In this same study, men were hesitant to reveal their sexuality. This is a problem because failure to do so is associated with misdiagnosis, delayed diagnosis and delayed treatment which in turn leads to a poor health prognosis and a greater HIV transmission risk. This is similar to findings in Malawi, Botswana and Namibia.

NEGATIVE ATTITUDES OF HCW'S

LACK OF EMPATHY/SENSITIVITY

*“The way I am treated makes me feel worse when I leave than when I came in.” —MSM****

*“We perceive them negatively and feel that they don't deserve our services. Some health workers don't like to examine them. They claim that such infections are self-inflicted.” —HCW**

LACK OF CONFIDENTIALITY

Ex. In 2011, a man appeared in a hospital emergency room for Post Exposure Prophylaxis (PEP). He was told to write his problem on an envelope and put it in a box from which the triage nurse collects notes every 15 minutes to prioritize cases. He waited 56 minutes and was then seen by the nurse. She said, “You don't need [PEP]; you're a boy, how do you go on engaging in anal sex.” This was said in front of other staff members without privacy or a sense of confidentiality. The patient left without the much needed urgent medical assistance.**

***Access to HIV Prevention and Treatment for Men Who Have Sex with Men: Findings from the 2012 Global Men's Health and Rights Study

* Experiences of Kenyan healthcare workers providing services to men who have sex with men: qualitative findings from a sensitivity training programme. van der Elst EM et al. Journal of the International AIDS Society 2013

** Capacity of Health Systems to Respond to the Health Concerns of Men who have sex with Men in Nairobi, Thesis by JOHN KINGORI NDUNGU

LIMITATIONS OF HCW AND HOW THE SYSTEM EXACERBATES THE STIGMA

INDIVIDUAL BARRIERS:

- Little to no professional training for HCW's makes them feel inadequately prepared because they lack the knowledge, skills and treatment guidelines. The present curriculum for VCT counselors does not take into consideration the possibility that male clients may be having sex with other men.
- Secondary stigma: HCWs may allot as short a time as possible to MSM for fear of being stigmatized him/herself

*As a result, for example, most of the VCT centers in Nairobi are not prepared to provide specialized prevention advice to the MSM community.**

STRUCTURAL BARRIERS:

- In one study HCWs described how limitations in assessment forms reinforce the invisibility of MSM in their clinics. By not collecting information about same-sex behavior or anal sex practices, these topics are reinforced as taboo issues that warrant silence and discomfort.
- HCW also described how the physical structure of the health facility hinders their ability to provide privacy and confidentiality for sexual health consultations

* Capacity of Health Systems to Respond to the Health Concerns of Men who have sex with Men in Nairobi, Thesis by JOHN KINGORI NDUNGU

Experiences of Kenyan healthcare workers providing services to men who have sex with men: qualitative findings from a sensitivity training programme. van der Elst EM et al. Journal of the International AIDS Society 2013



KNOWLEDGE GAPS: MEN WHO HAVE HAVE SEX WITH MEN

- How widespread is the notion of fatalism in the MSM community? And how does it impact their SRH?
- Explore the dichotomy between a group that engages in sexually risky behaviors (inconsistent condom use and multiple/concurrent partners) and still high levels of HIV testing. Are they in denial about the risks they face?
- To what extent does this audience engage in routine preventative behaviors (healthy eating, talismans, protective charms, etc.)? And why?
- Will PrEP offer an opportunity for these men to express themselves more freely (without giving them a license to have unsafe sex)? What are some other 'emotional problems' PrEP can solve for them?

FEMALE SEX WORKERS

“I am from a neighboring country and was introduced to sex work after my parents died. I moved to Kenya where police harassment, client abuse and accessing hospital facilities were some of the challenges I faced.”

– Anne, a sex worker in Kisumu
(Keeping Alive Societies Hope)



FEMALE SEX WORKERS THEMES

RELEGATED TO THE FRINGES OF SOCIETY

NOT COMPLETELY HELPLESS

BEING 'STREET-CONNECTED' PUTS HER AT GREATER RISK

UNABLE TO PROTECT HERSELF

WHO IS SHE?

Definition: Sex work is broadly defined as the exchange of money for sexual services. Persons who engage in sex work exchange sex acts for something of value including cash or material items that would otherwise not be extended to them by their sex partners. It is important to note that sex work is consensual sex between a sex worker and a client who gives something of value in exchange for sex.

AGE SEGMENTS: Majority below 30 years

MARITAL STATUS: Some are single, others married

MONTHLY INCOME: Earn between Ksh. **5,000-70,000**. Average is **15,000**

EDUCATION: 75% only attended primary education; some are illiterate

GEOGRAPHY: Urban, peri-urban

CRIMINALIZED: There are a number of laws specific to sex work that are used to criminalize and oppress sex workers, clients and third parties, which in turn fuels stigma, discrimination and violence against sex workers.

YOUNG: The average age of sex work debut in Mombasa, Kenya is only **17.6**, with almost two-thirds beginning sex work before the age of 18

MIGRATION AND SEX WORK OFTEN

CLOSELY LINKED: When African women migrate (e.g. after losing control over assets upon the dissolution of a marriage or death of a spouse), this may result in their reliance on transactional sex for income (Strickland, 2004).

HOT SPOTS: Her location of soliciting sex (bar/club based, street/truck based, brothel/home based, and beach based) determines what type of sex worker she is and where she conducts her business (inside a building or outside in the bushes, for example). Other hot spots include: taxi ranks, bus stops, fuel stations, shopping malls, massage parlours, parks, hotels, and casinos.

MAY BE A MOTHER: Average 1-2 Children. Commonly the economic motivation lies in the desire to send and keep children in school.

COULD BE IN A STABLE RELATIONSHIP: A substantial number of sex workers in Kenya are married or in stable relationships with regular partners*. Their sex work may not be disclosed to their partners or families.

A 'regular' partner has been defined as 'a long-standing non-commercial partner who did not give money or gifts in return for sex and towards whom the sex workers feels an emotional attachment'.*

Burden of HIV among female sex workers in low-income and middle-income countries: a systematic review and meta-analysis. Baral S, Beyrer C, Muessig K, Poteat T, Wirtz AL, et al. Lancet Infect Dis (2012) 12: 538–549.

"I expect to be abused and I have fear": Sex workers' experiences of human rights violations and barriers to accessing healthcare in four African countries. Final Report, April 2011

* Lafort Y, Greener R, Roy A, Greener L, Ombidi W, Lessitala F, et al. (2016) Where Do Female Sex Workers Seek HIV and Reproductive Health Care and What Motivates These Choices? A Survey in 4 Cities in India, Kenya, Mozambique and South Africa. PLoS ONE.

Nascopor. "National Key Populations Communication Strategy, 2014 – 2017." NASCOP. Web. 24 Jan. 2017.

“A sex worker, she’s thinking, when I wake up in the morning I think about how to feed my children. Yes I could maybe get (HIV) and die in 10 or 20 years but my children are alive today and they need food today.”

– Stakeholder Interview, Elizabeth Bukusi,
Medical Research Institute

HIV STATS

- Unknown number of FSW but the estimate stands at approximately **133,000** (TWG)
- **29.3%** prevalence
- **14.1%** of new adult infections every year
- **68%** have tested for HIV in the past year and know their status
- **70%** receive “targeted intervention services”

RELEGATED TO
THE FRINGES OF
SOCIETY

CONSIDERED LESS THAN HUMAN

FSW are often treated as objects: “You can tell the client to stop... he says, ‘Didn’t I buy you with my money?’”

They are often victim to regular human rights abuses: In one study, a theme that often emerged in that “sex workers cannot be raped.”

REGULARLY SUBJECT TO HUMILIATION, DISCRIMINATION, EXTORTION AND VIOLENCE:

FROM PARTNERS AND CLIENTS:

Ex. Faced with violence for refusing to have sex without a condom.

“My boyfriend harasses me because I am a sex worker and he demands sex....and if I refuse he rapes me.”
– FSW, Mombasa

FROM FRIENDS AND FAMILY:

“At home, my own father asked my mother not to give me food for even one day because if I could sell pussy, I was able to feed myself.”

– FSW, Mombasa

FROM THOSE ON THE FRINGES OF THE SEX INDUSTRY:

In one study, landlords demanded sex in exchange for accommodation or basic services: *“At home my landlord asks me to sleep with him or else he throws me out of his house.”*

“I have to give half of my money to them so that they treat me well and allow me into their bars.”

FROM POLICE:

Abusive law enforcement officers, accompanied by violence, extortion, sexual abuse, rape and mandatory testing for HIV and sexually transmitted infections, exacerbate the vulnerability of sex workers (UNAIDS GAP REPORT, 2014)

“I was arrested and ordered to remove my panties at gun point and I had to give into sex with [the police] and then I was let free.” –*Female SW, Mombasa

UNSUPPORTED BY THEIR FAMILIES

Sex work in some areas is condoned by families. A UNICEF study of underage sex workers noted that because of the high rates of poverty in the Coast region, many families condone sex work by their teenagers as a more lucrative way of obtaining the household income than menial labor.

NOT COMPLETELY HELPLESS

She may be victimized, but she doesn't
necessarily see herself as a victim.

SEX WORK CAN BE A MEANS TO SUPPLEMENTING HER INCOME...

Transactional sex helps girls and young women supplement earning from the informal sector.

“I enjoy my job as it is the only work that I know I am good at. I tried hawking and washing people’s clothes previously, but it was always a constant struggle. I cannot say the same of my current job. I love it and even if you offered me another kind of work, I will not take it.”

—Ruth Kanini, FSW, Huruma

“First, I love sex. Second, it gives me money. Third, I like travelling here and there and my work allows me to do that.”

– Female SW, Mombasa

...BUT IT'S NOT ONLY ABOUT ECONOMIC SURVIVAL

In one study while many of the FSW had clearly entered the sex industry for economic survival, and often in the face of severe poverty and unemployment, several found that the work gave them financial independence and the ability to improve their lives quite dramatically.



IF SHE CAN USE A CONDOM WITH CLIENTS, SHE WILL

According to a Polling booth survey conducted in Nairobi in 2011, **86%** of sex workers had used a condom at last sex.

However where the problem lies is with regular partners, not clients. Sex workers in Kenya and other parts of SSA use condoms frequently with clients, but not with their regular partners because unprotected sex is largely seen as an expression of love and trust.*

“(Reason being) her regular partner may pay her rent, her children’s school fees...so you start to look at this person differently. If he doesn’t want to wear a condom, you accept it. The sex worker could also be his wife, his property so the issue of condoms becomes uneasy.”

– Stakeholder Interview, Peninah Mwangi, Executive Director of BHESP

* *Barriers and facilitators to pre-exposure prophylaxis (PrEP) eligibility screening and ongoing HIV testing among target populations in Bondo and Rarieda, Kenya: Results of a consultation with community stakeholders. Mack et al. BMC Health Services Research 2014,*

“Many FSW are members of organized groups like Bar Hostess, like KESWA. These groups have benefits like protection, advocacy, correct information regarding SRH – so they also get their info from these organizations.”

– Stakeholder Interview, Mercy Kamau, Jilinde

*“...when we sex workers meet together, we discuss many issues and advise one another. We comfort ourselves and come with good ideas, which can help us and this makes us feel like we are also human beings and relieves us from stress.” – *Female SW*

FINDING POWER IN NUMBERS

MEET VIVIANE MUASI, 25

By night, Viviane is a sex worker in Kenya's capital, Nairobi, but when not canvassing for clients, she spends much of her time convincing other sex workers to test for HIV and use condoms.

She is also a peer educator with the Sex Workers Outreach Programme (SWOP) - a project run by the University of Nairobi and Canada's University of Manitoba.



BEING
'STREET-CONNECTED'
PUTS HER AT
GREATER RISK



MIGRATING TO THE CITY OFTEN RESULTS IN WOMEN FINDING THEMSELVES “ON THE STREETS”

- Women’s levels of internal migration have met or far exceeded those of men.
- Many girls and young women are moving to the cities in search of a “better life” and finding themselves in slums or on the streets.
- Population-based studies have found HIV rates twice as high in informal settlements compared to urban and rural areas (Boerma et al. 2002; Coffee et al. 2005; Shisana et al. 2005)
- Transactional sex among girls has also been described as a requirement for girls on the street to facilitate survival.

“If your man is around, you will just be with him but if he is not around, for example if he is jailed, you cannot stay hungry as you wait for him. You will look for another man to have sex with so that you can get money. So during such times, you will be sleeping with any man who comes across as long as he has money to give you.” – (Female, 21)



IF THEY ARE 'STREET-CONNECTED' DRUGS AND ALCOHOL ARE CURRENCY

Drugs and alcohol are commonly traded for sex between street-connected boys and girls:

“For me when I do it, I usually pay like 150, 200 or 100 shillings (~ **1.14 –2.28 USD**) although there are other girls who just need glue or alcohol. You can buy her alcohol then when she drinks, she accepts to have sex with you” – (Male, 18)

In other cases drugs or alcohol are used to seduce a girl or lower her inhibitions. She is then usually forced to have sex in these cases to pay for the drugs and/or alcohol consumed.

OFTEN UNABLE
TO PROTECT
HERSELF



MISINFORMED

- In the IBBS survey **1 out of 4** sex workers did not know that condom use, and that having one faithful uninfected partner protects against HIV.
- Nearly one-fifth were misinformed that mosquito bites transmit the virus.
- And about **3 out of 4** sex worker respondents still think that a healthy-looking person cannot have HIV.

SAFE SEX PRACTICES CAN BE THWARTED BY CLIENTS

Ex. Sex workers whose clients offer to pay double in order to have unprotected sex.

OR THE AUTHORITIES

“Why is the government giving me condoms when I can’t carry them without going to jail?”

In Kenya, police use the possession of condoms as evidence of sex work, leading to the arrest of the individual and confiscation of their condoms (UNAIDS GAP REPORT, 2014)

STEEP BARRIERS TO ACCESSING HEALTH CARE

DISCRIMINATION AT THE HANDS OF HCW:

- In one study FSWs described many instances of poor treatment once health providers – particularly those in public clinics and hospitals – became aware of their work. They were said to ask invasive and unnecessary questions of SW and frequently breached patient confidentiality. For many SW in this study, health providers were plainly described as “abusive” or “hostile”: “We are despised in the hospitals. They say, ‘We don’t have time for prostitutes’ and they also say that if one prostitute dies then the number reduces.”
- Sometimes SW had to pay health workers additional money for services, especially for STI treatment, and were almost always turned away if unable to bring their sexual partner to the clinic.

OTHER BARRIERS INCLUDE:

- Lack of knowledge of where to go or money to pay for the services
- Long wait times, inconvenient operating hours
- Negative partner influences

“Most of these health workers at public hospitals, they discriminate against me. They don’t take me as a patient...they mistreat us like we are not human beings.”

*– *Female SW, Mombasa*

FORCED TO RESORT TO ALTERNATIVES

Sex workers sidestep clinics and hospitals altogether and resort to self-treatment or the services of traditional healers.

“The only thing that forces me to go to hospital is abortion. Whenever I forget to use a condom I get pregnant but I don’t like hospitals. I buy medicines from pharmacies and terminate my pregnancy. I use alcohol to remove pain.” – Female SW, Mombasa

“After sex, they shower and wash vagina with water. Or, urinating immediately after unprotected sex. (FSW also) go to a witch doctor (Mchawi), who gives them protection with lotions/oils which they can apply every day, or can give feather of a chicken or a necklace..” – Stakeholder Interview, Grace Kamau, KP Consortium

Others try to be selective, avoiding particular facilities where providers are known to be cruel and stigmatizing, or are likely to withhold treatment or ask too many questions.

Another common solution, provided she has enough money, is to access private health care as private care is perceived as higher quality than public health services.

KNOWLEDGE GAPS: FEMALE SEX WORKERS

- Do they self-identify as sex workers in part or at all? What words do they use to describe the work that they do (other jobs + sex work)?
- To what extent do sex workers have other jobs to supplement their income? To what extent is this influenced by where they live (rural vs. urban)?
- To what extent does this audience engage in preventative behaviors (antenatal visits/prenatal vitamins, healthy eating, talismans, protective charms etc.)? And why? (Not only related HIV prevention)
- Will PrEP offer an opportunity for these women to feel more empowered? Is empowerment meaningful for FSW? What are some other 'emotional problems' PrEP can solve for them?

PEOPLE WHO INJECT DRUGS

“They’re rejected by society. Even their families reject them. They’re isolated. They’re criminalized. They’re seen as hopeless people.”

– Calleb Angira, Director of the Nairobi
Outreach Services Trust



PEOPLE WHO INJECT DRUGS THEMES

SMALL POPULATION,
GROWING IMPACT ON THE HIV EPIDEMIC

THE RISK FOR HIV COMPETES WITH OTHER PROBLEMS

RECEPTIVE TO RECEIVING HEALTH CARE

BARRIERS EXIST

HARM REDUCTION: SOME PROGRESS

WHO ARE THEY?

Definition: An injecting drug user is defined as a person who injects drugs for nontherapeutic purposes, irrespective of the type of drug injected

MARITAL STATUS: Majority not in union (Single, separated, divorced, widowed)

FAMILY: Very few have children who are very young; most children are born out of wedlock

RELIGION: Most PWID in Nairobi are Christians, while majority in Coast region are Muslims

EDUCATION: **50%** primary school; **44%** secondary school

CRIMINALITY: 14% engage in petty crime for their livelihood (snatchers, pickpockets, shoplifters)

USERS ARE YOUNG, URBAN, POOR AND MALE

- Injecting drug users are concentrated in Nairobi and urban coastal cities and likely to grow across urban centers
- Users live in poverty, and lack work, housing or social support
- **80%** are aged between 20-35 years old, median age 33 years
- **90%** male; **10%** female
- Income: Most unemployed (about 90% casual labor, criminality)

USERS HANG OUT IN GROUPS/PARTNERS

- They pair with a ‘partner’ to raise cash, hang out, and use together
- Can use in dens as social groups, and live close to source of drugs

MANY ARE INCARCERATED

- Heroin, the most commonly injected drug, is illegal in Kenya
- As a result, large numbers of users are incarcerated

HIV STATS

- Estimated **18,000-60,000** people
- **18.3%** prevalence
- **3.8%** of new adult infections per year
- **60%** tested for HIV in the past year and know their status
- **24%** receive targeted intervention services

AllAfrica.com

Tun et al. 24-35

The Global State of Harm Reduction Report, 2014

http://www.unaids.org/sites/default/files/media_asset/05_Peoplewhoinjectdrugs.pdf

Injection drug use, unsafe medical injections, and HIV in Africa: a systematic review. Savanna R Reid. Harm Reduct J. 2009;

6: 24. Published online 2009 Aug 28

Nascopor. “National Key Populations Communication Strategy, 2014 – 2017.” NASCOP. Web. 24 Jan. 2017.

SMALL POPULATION, GROWING IMPACT ON THE HIV EPIDEMIC

The number of PWID across the country has been rising.



*Risky behaviors are greatly contributing
to the spread of HIV amongst this group:*

RISKY NEEDLE SHARING

- In one study, two-thirds of PWID engaged in at least one risky injection practice in a typical month
- Young IDUs more likely to engage in risky needle sharing practices

RISKY SEXUAL PRACTICES

- Multiple partners: Nearly one-quarter (**23%**) had more than one partner the last year
- Low condom use during sex, compared to non-IDU
- Female users are also often sex workers

Fox News, 2016

Guise A, Dimova M, Ndimbii J, Clark P, Rhodes T. 'A qualitative analysis of transitions to heroin injection in Kenya: implications for HIV prevention and harm reduction'. Harm Reduction Journal, September 2015.

<http://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-015-0061-2>

HIV and STI Prevalence and Injection Behaviors Among People Who Inject Drugs in Nairobi: Results from a 2011 Bio-behavioral Study Using Respondent-Driven Sampling: AIDS Behav (2015)

Injection drug use, unsafe medical injections, and HIV in Africa: a systematic review. Savanna R Reid. Harm Reduct J. 2009; 6: 24. Published online 2009 Aug 28

HIV Prevalence, Estimated Incidence, and Risk Behaviors Among People Who Inject Drugs in Kenya. J Acquir Immune Defic Syndr. 2015 Dec 1

THE RISK FOR HIV COMPETES WITH OTHER PROBLEMS

DONALD*

Donald is homeless, and faces a number of challenges linked to this; violence from officials, shortage of food, and ill health linked to a lack of shelter. Despite these challenges, he is able to adhere to his HIV treatment with the support of the outreach projects and the flexibility of the clinics.

STEPHEN*

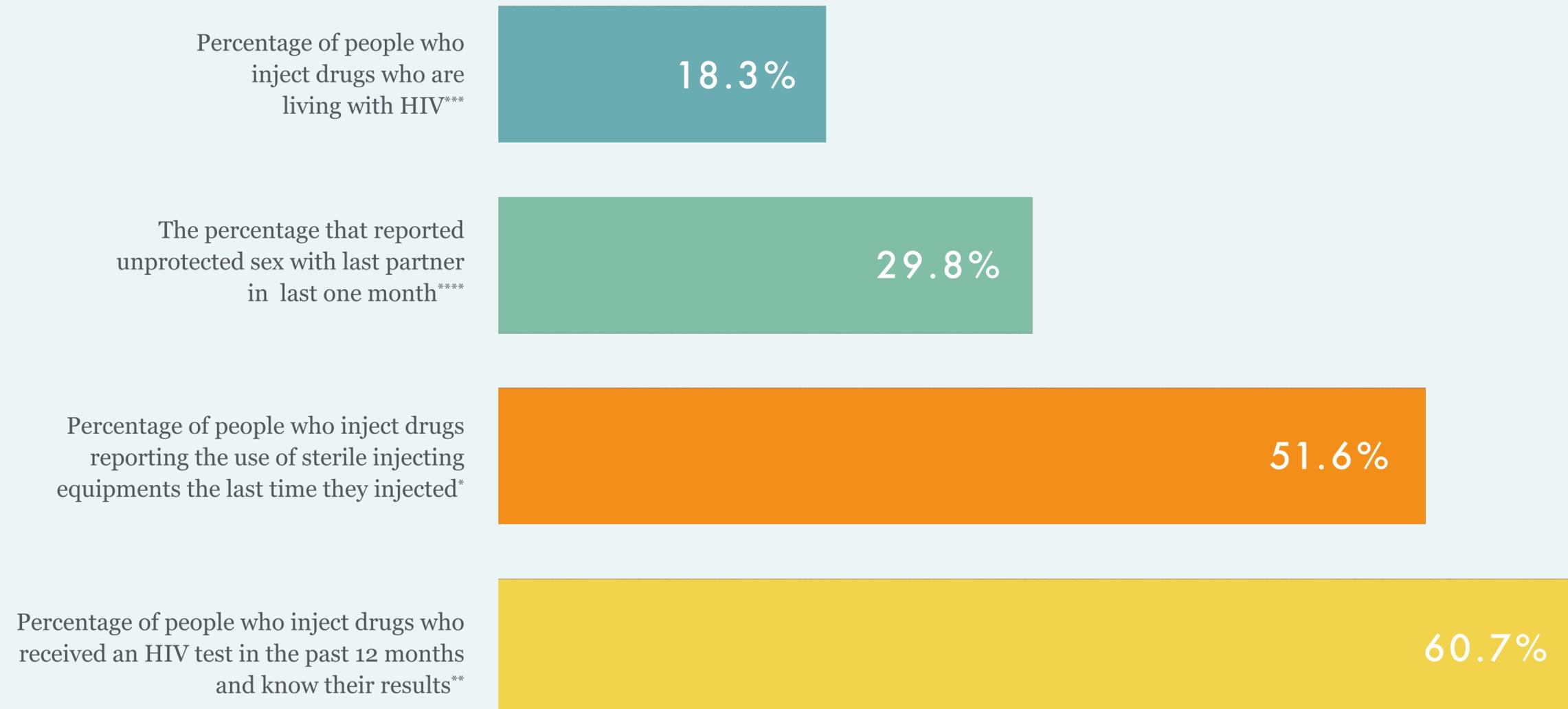
Stephen worries for his health, and tests regularly for HIV. He faces challenges though: serious abscesses after injecting, making him very ill. A shortage of money and food, and violence from the community are other challenges he and others face.



RECEPTIVE TO HEALTH CARE



6 IN 10 HAVE TESTED FOR HIV AND KNOW THEIR STATUS



* Integrated Bio-behavioural Survey conducted by Population Council 2010/2011

** Integrated Bio-behavioural Survey conducted in Nairobi, 2011

*** Study conducted in Nairobi regions in 2011 by UNODC

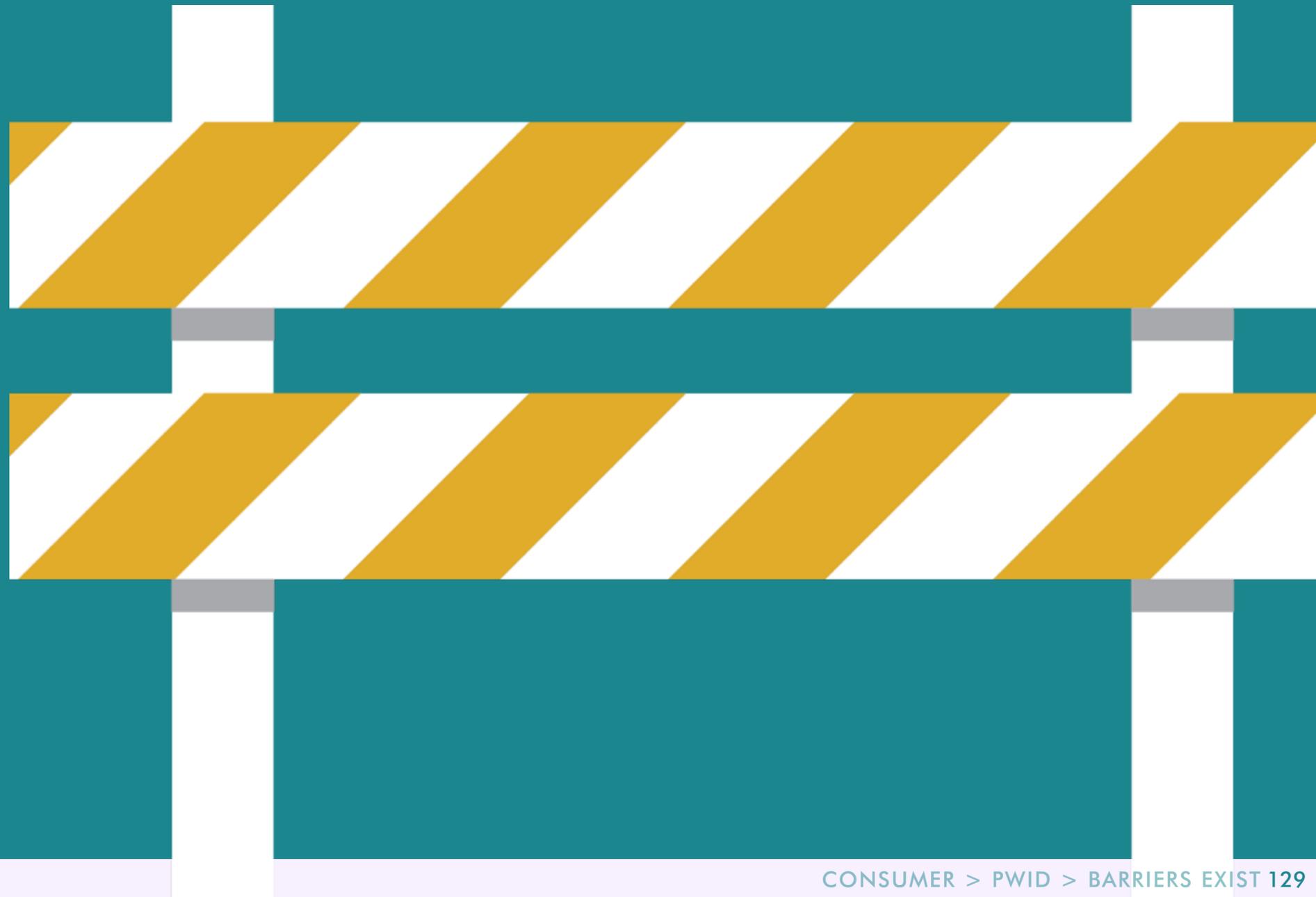
**** Integrated Bio-behavioural Survey conducted by Population Council, 2011

*“Drug users live on the edge of society where people want to do things to them and not with them. Our experience is that **if you reach out to drug users and provide services to them in a safe and nonjudgmental way, they are very eager and willing participants.**”*

"If they are given access to safer approaches, they will take them and they will use them. Starting with healthcare providers, humane treatment can make a world of difference.”

– Chris Beyrer, president of the International Aids Society

BARRIERS EXIST



FEAR OF DISCRIMINATION

“When you go there he tells you to go back and bathe first, then come back. You see? Sometimes he tells you, sit there. He segregates you from others, tells you to sit somewhere else, he will attend to you later, now you see, you start feeling like you do not belong in such a place. You see that, you go away.”

**MUST
CHOOSE
BETWEEN
ADDICTION
OR CARE**

“If I need to go to hospital today and I have not dealt with withdrawal, I will not go to hospital, you see?”

FEAR OF COMMUNITY STIGMA

“I’m afraid to go and... I’m afraid, I don’t know why... I can go to the hospital to have some help. Then I go back... Why do you feel afraid of the treatment of the hospital? I don’t know, I don’t like so many people to see I’m sick.”

ACCESS TO HEALTHCARE IS LIMITED IN PRISONS

Prevention, treatment and support services are limited in Kenyan prisons, despite drug-using inmates expressing their interest.

Female PWID risk facing additional stigma and discrimination due to their participation in sex work

1. *Access to HIV Treatment and care for people who inject drugs in Kenya: A short report (2016)*
2. *AIDS 2014: Peer programs engage injection drug users in Kenya and Tanzania*
3. *A 2015 report by Emmy Kageha, [Drug Laws and Human Rights in Kenya](#)*

HARM REDUCTION: SOME PROGRESS





COMBINATION PREVENTION

UNAIDS Report (2014) highlighted that a **combination prevention approach** has the greatest and most cost-effective impact on the HIV epidemic among people who inject drugs.

This includes:

- ✓ Needle and syringe programs
- ✓ Opioid substitution therapy
- ✓ HIV testing and counselling
- ✓ Antiretroviral therapy

HARM REDUCTION SERVICES ARE EXPANDING IN KENYA

Since the introduction of harm reduction in Kenya in 2012, almost **10,000 PWID** have been reached with clean needles and syringes, and sexual and reproductive health information and services.

WITH SOME POSITIVE RESULTS

90% of PWID reported that they had acquired knowledge on how to prevent HIV through avoiding re-use of needles/syringes.*

Percentage of PWID reporting using a clean syringe the last time they injected increased to nearly **90%**, compared to only **51.6%** in 2012.*

HOWEVER THESE SERVICES DON'T SEEM TO BE ROLLING OUT AS RAPIDLY AS THE POPULATION IS GROWING

Only **1 in 4** receive targeted intervention services (Kenya Prevention Revolution Roadmap, MOH, 2014).

* Figures based on a total population of 18,000 (2011 estimate).

[Community Action on Harm Reduction: Achievements and Challenges in Introducing Harm Reduction in Kenya, April 2016](#)

KANCO (2014), End line evaluation report for the community action on harm reduction project in Kenya.

Mutuku, A.

11 International HIV/AIDS Alliance (2014), Independent Evaluation: Community Action on Harm Reduction (CAHR). Shaw G.

KNOWLEDGE GAPS: PEOPLE WHO INJECT DRUGS

- Are there any “friendly” healthcare services for this population?
- What role, if any, does fatalism play as a barrier to accessing treatment and care?
- Have most PWID tested for HIV because of their fear of unsafe needles or unsafe sex? How aware are PWID that unsafe sex puts them at risk of contracting the HIV virus?
- To what extent does this audience engage in routine preventative behaviors (antenatal visits/prenatal vitamins, healthy eating, talismans, protective charms etc.)? And why?
- Explore the nature of this group’s relationship with non-PWID.
- Will PrEP offer an opportunity for these women and men to feel more empowered? What are some other ‘emotional problems’ PrEP can solve for them?



HEALTH CARE WORKERS

“At the heart of each and every health system, the workforce is central to advancing health.”

WHO ARE THEY?

A DIVERSE GROUP

The term “Health Care Worker” spans a variety of health sector jobs.

PRIMARY PROVIDERS OF CARE

Nurses & midwives provide the large majority of primary health care services and are the first-line responders to a wide array of health issues, including HIV, particularly in rural areas.

Smith, 2016; Turan, 2008

TABLE 8: HEALTH WORKERS DISTRIBUTION BY CADRES CATEGORY, 2013

Cadre Category	Number of HW	Percentage of HW	Density per 1,000 people
Medical officers	1,424	4.58%	0.0342%
Pharmacists	413	1.33%	0.0099%
Pharmaceutical technologists	732	2.36%	0.0176%
Laboratory technologists & technicians	3,032	9.76%	0.0729%
Health records and information officers & technicians	558	1.80%	0.0134%
Nutritionists	364	1.17%	0.0087%
Registered clinical officers	3,236	10.42%	0.0778%
Physiotherapists	296	0.95%	0.0071%
BSc in nursing	537	1.73%	0.0129%
Kenya registered community health nurses	18,212	58.63%	0.4377%
Dentists and dental technologists	270	0.87%	0.0065%
Public health officers and technicians	1,652	5.32%	0.0397%
Radiographers	222	0.71%	0.0053%
Community oral health officers	112	.036%	0.0027%
TOTAL	31,060	100%	0.7465

HEALTH CARE WORKER THEMES

ON THE FRONTLINE

WORKING AGAINST ALL ODDS

PATIENT-PROVIDER RELATIONSHIPS ARE STRAINED

ENOUGH IS ENOUGH

STRUGGLING WITH THE SAME ISSUES AS THEIR PATIENTS

ON THE FRONTLINE

HAZARDOUS WORK ENVIRONMENTS

Limited resources and poor working conditions put health care workers at greater risk.

E.G. NSI'S

Accidental Needle Stick Injuries (NSIs) occur frequently among healthcare workers, particularly nurses. A country-wide study of 650 staff found the incidence of NSIs to be almost 1 per health worker per year.

HCW'S DOUBT THEIR SAFETY AT WORK

When asked whether they were concerned about contracting an infection at work, a majority of health workers (**80%**) said yes. Specifically, **60%** were concerned about contracting HIV at work.

“In case there is an accident, for instance, in the operating theatre. It is just that you work with a lot of fear. The problem here is that you can get infected because of the nature of our work, but nobody will understand that you got it because something pricked you. People will only see the promiscuity in you.” –Nurse, Private Maternity Hospital



THEY ARE SOMETIMES VICTIMS OF STIGMA THEMSELVES

Because they work with PLHIV, Health Care workers are often the victim of associated/secondary stigma: incidents that describe stigma against people who work or associate with HIV/AIDS-affected people.

CARRYING A HEAVY PERSONAL BURDEN

DEMANDING & STRESSFUL

Caring for PLHIV is demanding and stressful for the staff involved. Health care workers face challenges of obtaining consent, protecting confidentiality, providing counselling and helping often emotionally unstable clients manage disclosure while in fear of becoming infected themselves.

EMOTIONALLY CHALLENGING

In many cases, it is up to the health worker who is delivering the test results to counsel the patient afterwards, which can be particularly difficult.

FACING ETHICAL DILEMMAS

Many health workers are faced with ethical dilemmas when by keeping a patient's status confidential they are putting another party at harm.

“I have two or three cases where one [partner] is positive and does not want to inform the partner they want to marry. [In this case] you cannot say anything because it is confidential; really it hurts because it is as if it was a crime you saw committed but you could not help prevent it.”

“There are times when you don't sleep because of certain couples who do not share results.”

WORKING AGAINST ALL ODDS

UNDERSTAFFED

- The doctor to patient ratio is **1:17,000** against WHO's ratio of **1:1,000**
- Just four counties met Kenya's benchmark of **8.7** nurses per **10,000** people

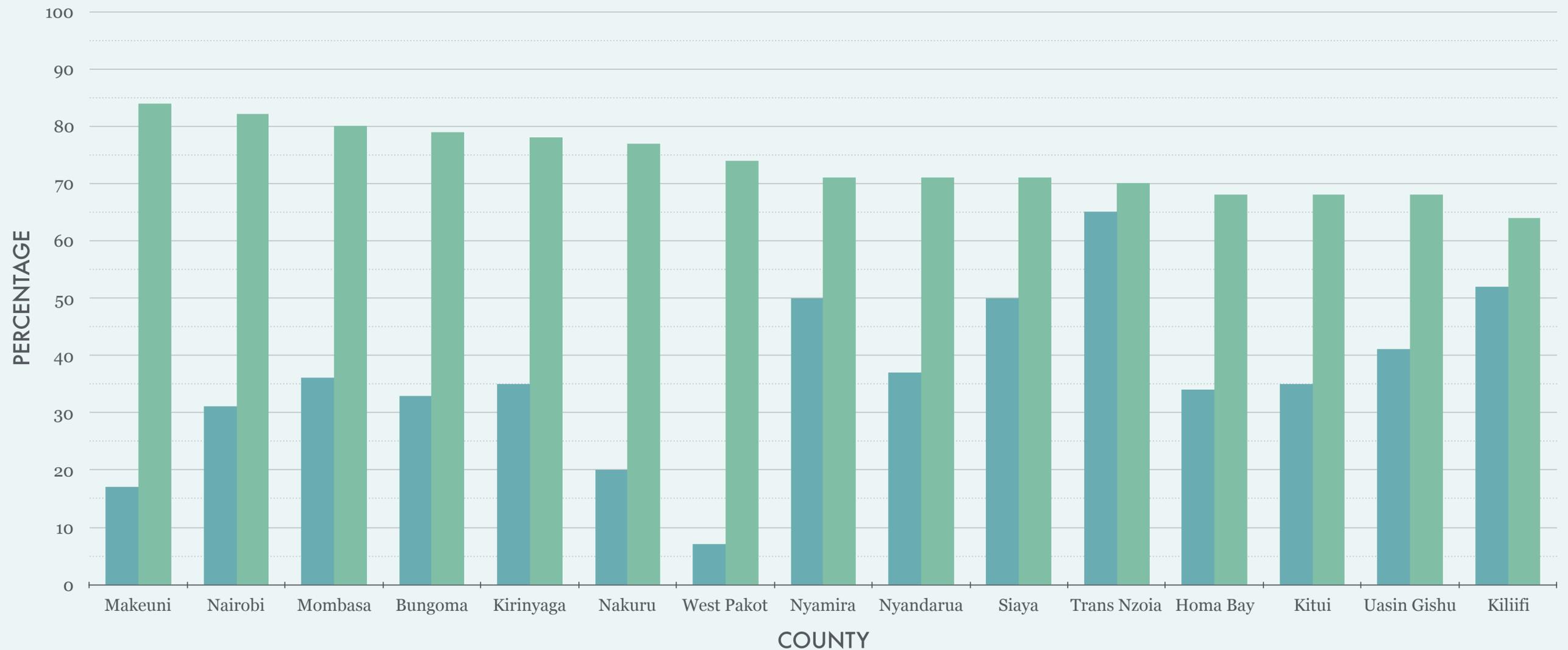
UNEVEN GEOGRAPHICALLY DISTRIBUTED

- The distribution of testing sites is skewed; **60%** are based in the urban/peri-urban areas where only **20-30%** of the population live
- Densely populated Mombasa and Nairobi have 134 and 124 health facilities per 100 square km, respectively, but far fewer facilities per 10,000 people (2.9 and 2.4, respectively)*
- Mobile sites for remote rural areas are being promoted to cater for this imbalance
- Health care facilities in slums operate illegally, leading to malpractice and poor quality of health

HIGH STAFF ABSENTEEISM (AND IN TURN, LOW STAFF

Staff absenteeism varies greatly by county, from 7 percent in West Pokot to 65 percent in Trans-Nzoia

- AVERAGE PERCENT OF STAFF ABSENTEEISM
- AVERAGE PERCENT CORRECT DIAGNOSIS (all 7 cases) AMONG CLINICIANS



RELUCTANT TO ADOPT NEW PROTOCOLS WITHOUT ADEQUATE SUPPORT

LACK OF RESOURCES

While adopting new regimes or protocols can improve the quality of care, health workers may be reluctant to adopt them because of staff shortages and increases in patients.

LOW-SELF EFFICACY

One-third of nurses working in health facilities with shortages of clinicians at the time of the one study had not been trained in comprehensive HIV care and treatment, and more than half had not been trained to prescribe first-line ART.

UNSATISFIED WITH THEIR JOBS

LACK OF TRADITIONAL MOTIVATION AND RETENTION FACTORS

Healthcare workers are unsatisfied with their remuneration, material and equipment, freedom of working methods, and possibilities for career development.

“It depends on internal motivations, but if you are out to make money (many HCW's) would prefer a private (health care) facility. Private facilities pay better and are better equipped.”

–Stakeholder Interview, Caroline Ng'eno,
Regional Director, ICAP

BROKEN PROMISES

In June 2013, in light of the decentralization of healthcare in Kenya, the government signed a new Collective Bargaining Agreement to improve the salaries and benefits of Health Care Workers in Kenya.

Four years later, despite signing the agreement, what was agreed upon has not been implemented yet.

UNFAIRLY LABELED AS "LAZY," "NOT-CARING," "NEGLIGENT"

Stories in the news and comments made by government officials on health workers frequently frame them in bad light, but often for reasons out of their control, such as a drug stockout, power loss, and lack of pay.

Ex. Health care workers in Nairobi were accused of negligence after patients died when they failed to report to work. However, the health workers chose to not report to work because they had not been paid in over four months.

MP Mtengo riled by poor healthcare, wants Malindi boss fired

Aug. 08, 2016, 12:00 pm | By ALPHONCE GARI, [@alphonnce2011](#)

Mtengo said: "This is unacceptable. I came here very early. There are no doctors to attend to patients. People are suffering because of laxity among staff."

LIMITED RESOURCES AND POOR WORKING CONDITIONS

OUTDATED AND OUT OF STOCK

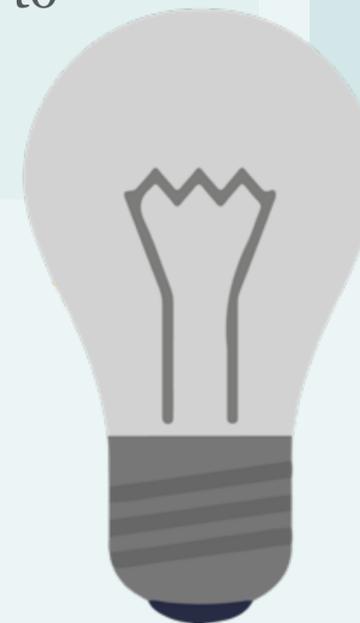
Medical technology, if available, is often outdated. Medications and diagnostic resources are frequently out of stock, or unable to be stocked due to improper conditions.

CAN'T KEEP THE LIGHTS ON

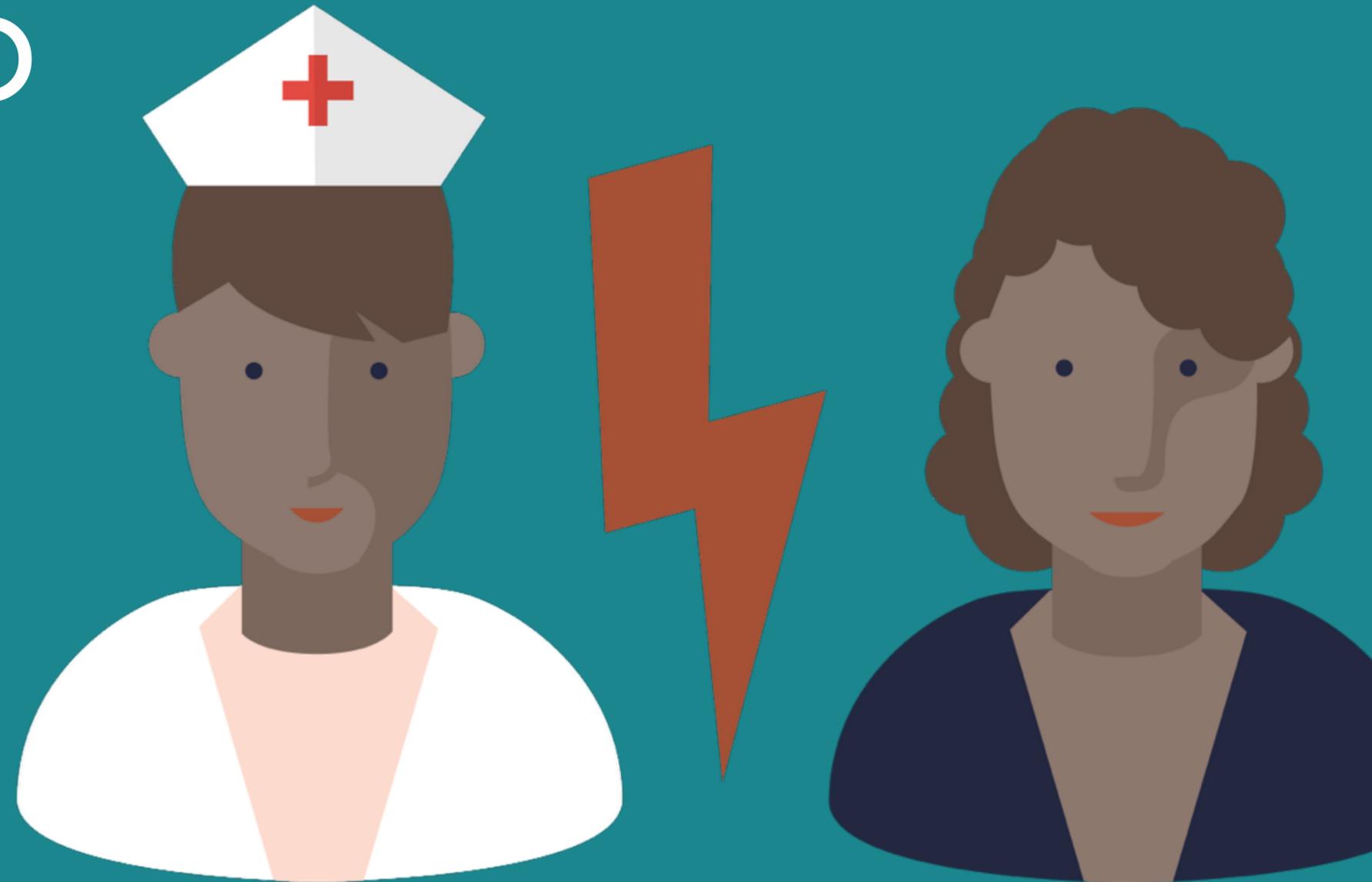
Some rural clinics are only open during daylight hours, or are frequently closed due to lack-of or no electricity.

NO PRIVACY

Many clinics lack private physical space. Some health workers described having to deliver HIV test results in places where they could be overheard by other patients, staff or relatives.



PATIENT-PROVIDER RELATIONSHIPS ARE STRAINED



“LACK OF CLIENT FRIENDLY SERVICES”

In some facilities if someone doesn't adhere to their clinic appointments, he/she is subject to scolding and punishment from health care providers. In many cases, this may be driven by established belief among health workers that this approach is in the best interest of the patient and will result in improved adherence and retention to care. Yet this behavior often deters patients and leads to decreased efficacy.

BIASES INFLUENCE THE CARE OFFERED

Traditional family values, stereotypes of abnormality, gender norms and cultural and religious influences underlie intense stigma and discrimination of a number of vulnerable and minority groups. Often this stigma and discrimination interfere with the delivery and quality of care.

These groups include MSM, FSW and PWID.

“Services in government hospitals are not good. You will be looked down upon, they can even send you away ... or ask you insensitive questions; you see we really need a lot of confidentiality.” –Sex Worker



ENOUGH IS
ENOUGH

STRIKES

In light of the government's reluctance to enact the CBA of 2013, health care workers throughout Kenya have been on strike since late 2016.

This is not the first large-scale strike amongst Kenya's health workers to have occurred.



Striking health workers at Uhuru Park in Nairobi, September 2015.

President Kenyatta pledges to fix health workers issue amid strike

KERICHO (Xinhua) -- Kenyan President Uhuru Kenyatta has said that his government will resolve issues doctors and nurses have raised but urged them not to make innocent patients suffer as strike entered its fifth day.

HIGH TURNOVER RATE

Due to poor working conditions and low rewards, Kenya's health workforce has an extremely high turnover rate.

Notably, more than **50%** of physicians and an alarming **81%** of enrolled community nurses left the health workforce.



STRUGGLING WITH THE SAME ISSUES AS THEIR PATIENTS

DON'T WANT TO GET TESTED

Paradoxically, healthcare workers often feel unable to access treatment, care, and support services themselves. While their profession places them in close proximity to those services, it also exposes them to heightened stigma when they test HIV positive, making them more reluctant to seek HIV services.

In studying occupational safety issues among healthcare workers in Kenya it was revealed that the uptake of Post-Exposure Prophylactics was astonishingly low (4% of those who had NSIs) because health workers didn't want to get tested and know their status.

LACK OF "CLIENT-FRIENDLY" SERVICES

To date, there have been few HIV prevention, treatment, or support services targeted specifically toward health care workers.

KNOWLEDGE GAPS: HEALTH CARE WORKERS

- What are some of the motivations, if any, behind becoming a health care worker given the high risk/low reward nature of the profession?
- How are frequent transfers of HCW's affecting the continuity of services, the quality of delivery of services as well as patient/provider relationships?
- Is there a way to reconcile/better understand the challenges female HCW may have faced as young women (e.g. unwanted pregnancy, sexual violence, early sexual debut etc.) and her personal biases that result in her not providing judgment-free services to AGYW today?
- What opportunities can PrEP offer for this audience? What 'emotional problems' can PrEP solve for them?
- Need to better understand a HCW's customer journey towards coming to understand and accept PrEP as an effective method of HIV prevention, thus offering it to high risk patients.
- When, where, and how do health care workers receive training or information related to HIV prevention services and/or new protocols?
- What is the process for training (any kind of training, including sensitivity training)? Is it mandatory or do they need to volunteer for new training?
- Where, when, how do health care workers connect with each other (besides at work)?
- Who can they go to for leadership, emotional support, etc.?
- What are HCW's attitudes and beliefs surrounding the private sector (vs. the public sector)? Is it more desirable to work in the private sector? Are many HCW's moving from the public to the private sectors?
- The uptake of post-exposure prophylactics among HCW's is astonishingly low (4% of those who had NSIs). Why is this?

CATEGORY

The overall category dynamics
and conventions relevant to
HIV prevention

COMP

CONSU

CATEGORY THEMES

STILL THE #1 KILLER IN KENYA

NO ONE HIV PREVENTION APPROACH STANDS ABOVE THE REST

THE UNFAMILIAR CONCEPT OF PROPHYLACTIC TREATMENT IN THE CONTEXT OF HIV

STRUCTURAL ISSUES THAT EXACERBATE THE GAPS IN CARE

DISTRUST OF THE HEALTH CARE SYSTEM

MOH HIV COMMUNICATION CAMPAIGNS

AIDS IS STILL THE #1 KILLER IN KENYA

Given that the rate of reduction of new HIV infections in Kenya has been slow (only a 7% reduction from 2007 to 2013), Kenya is a prime country for the launch of PrEP as an HIV intervention.

WHILE KENYA HAS SEEN SUCCESS WITH HTC, VMMC AND ARTs, CERTAIN CHALLENGES STILL EXIST:

- Only **47%** of PLHIV know their correct status
- Despite knowing where to get tested, only **1 out of 2** adults has been tested
- Many people still find condoms difficult to acquire forcing some men in rural Kenya to wash and reuse their condoms. Even where they are readily available, they are not necessarily used (it's difficult to promote condoms simultaneously with abstinence)
- Condom distribution in the country is very low throughout and unequal, ranging from almost negligible in North Eastern to **1.65 per person per year** in Western Province. The three provinces with the highest prevalence are Coast (**0.49 condoms per person per year**), Nairobi (**0.81**) and Nyanza (**1.06**). (Kenya MOT Report 2009)
- There is a lack of counseling, testing, treatment and prevention services aimed at youth, especially youth who are already HIV-positive. Only **7%** of healthcare centers in Kenya can be considered youth-friendly.

KENYA HIV PREVENTION REVOLUTION ROADMAP: COUNTDOWN TO 2030

In order to eliminate HIV by 2030, the Prevention Revolution Roadmap proposes four major shifts in HIV prevention paradigms:

- From intervention driven to populations driven HIV responses
- From heavily biomedical dependent to a combination prevention approach embracing biomedical, behavioural and structural interventions
- From health sector driven to HIV prevention that is everyone's business
- From a national approach to geographical (county clusters) approach

FIGURE 2: RETHINKING HIV PREVENTION



THE HIV BURDEN IN THE 47 COUNTIES IS NOT HOMOGENEOUS

Some of the counties such as HomaBay, Kisumu and Siaya have reached hyper endemic situation where the adult HIV prevalence rate stands between **19.9% - 26%** (compared to the national prevalence rate of **5.9%**)

Similarly the pattern of new infections in the counties is not uniform with annual adult infections as high as an estimated **9,629** in Nairobi and as low as **28** in Wajir County (2015).

51% OF THE NEW INFECTIONS OCCUR IN 5 COUNTIES

HOMA BAY

New Infections: 9,629
Prevalence: 26%

KISUMU

New Infections: 8,790
Prevalence: 19.9%

SIAYA

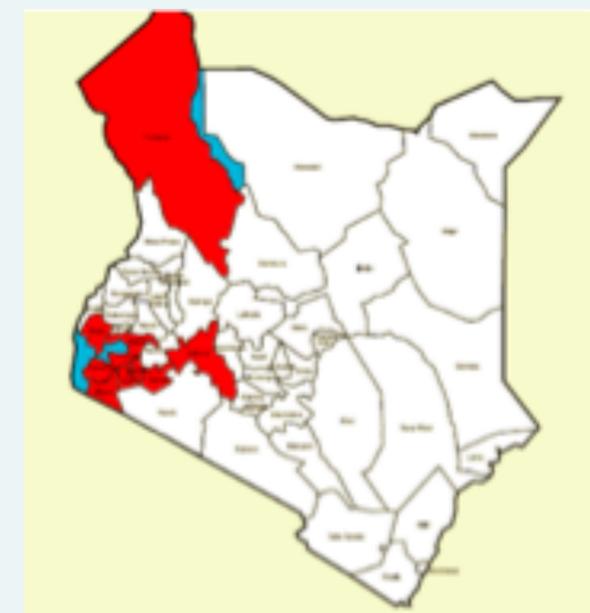
New Infections: 7,700
Prevalence: 24.8%

MIGORI

New Infections: 5,093
Prevalence: 14.3%

NAIROBI

New Infections: 4,719
Prevalence: 6.1%



NO ONE HIV PREVENTION APPROACH STANDS ABOVE THE REST

Comprehensive, unfragmented, combination prevention is seen as the way to eliminate HIV by 2030 however there are certain barriers that need to be taken into account especially as they relate to abstinence and male/female condoms.

ABSTINENCE

- Abstinence is heavily promoted, while in some educational settings, information on condoms is lacking.
- This helps explain why comprehensive knowledge about HIV prevention is low.

“Only 54% of young women and 64% of young men had comprehensive knowledge about HIV prevention.”

CONDOMS

- The government has actively promoted the use of condoms since 2001.
- Distribution has substantially increased. In 2013, around 180 million free condoms were distributed although this fell far below demand.
- Men may reuse condoms or use plastic bags & cloth rags due to shortages and difficulties accessing supplies.
- Only 40% of women and 43% of men who had two or more partners in the last 12 months reported using a condom the last time they had sex.

FEMALE CONDOMS

- Uptake and distribution of female condoms continues to be low.
- Barriers to uptake include product availability, high cost of these condoms vs. male condoms, low awareness among men and women, product misconceptions and resistance among men, and health provider bias.

VOLUNTARY MEDICAL MALE CIRCUMCISION (VMMC)

Kenya launched its VMMC programme in 2008. It aimed to conduct **860,000** circumcisions by July 2013 (**80% coverage**).

Between 2008 and 2013, the number of annual operations conducted increased dramatically from **8,000 to 190,000**. The country fell just short of its target, reaching 800,000 men (**71%**) but achieved its coverage goal in the Nyanza region where most of the implementation took place.

The next phase of Kenya's VMMC strategy aims to see **95%** of men aged 15 to 49 years circumcised by 2019. The country also aims to encourage safer surgical practices among traditionally circumcising communities.

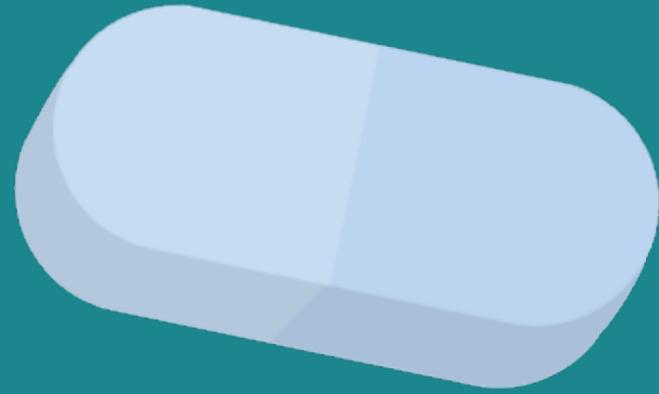
VMMC is thought to have a limited public health benefit if introduced among [key affected populations](#) such as SW, PWID AND MSM. However, individual men may benefit if they are at a higher risk of heterosexual HIV transmission because they are in a mixed-status relationship.



THE UNFAMILIAR CONCEPT OF PROPHYLACTIC TREATMENT IN THE CONTEXT OF HIV

“I’m not sick so it feels strange to take a pill everyday.”

- Woman at the AIDS Conference, 2016



PEOPLE UNDERSTAND THE CONCEPT OF 'PREVENTION'

Other examples of traditional preventative techniques or cultural practices also show that 'prevention' is not a foreign concept.

These include:

- Protective charms (yadh-ndgala)
- Tattoos
- Talismans
- Protective magic in the form of amulets and medicines (Buluyia, Western Kenya)
- 'Traditional vaccinations' (introducing herbs into skin incisions)
- Ceremonial rites of passage

"People understand prevention. For example, people understand taking pills to prevent malaria for a short time. Mothers understand taking pills when they are pregnant."

–Stakeholder interview, Elizabeth Bukusi, Chief Research Officer

BUT NOT THE CONCEPT OF PROPHYLACTIC TREATMENT, ESPECIALLY IN THE CONTEXT OF HIV*

"But now with HIV, pills are associated with ART, with HIV treatment. Prior to HIV taking pills was acceptable. Another example is that taking iron pills was very acceptable."

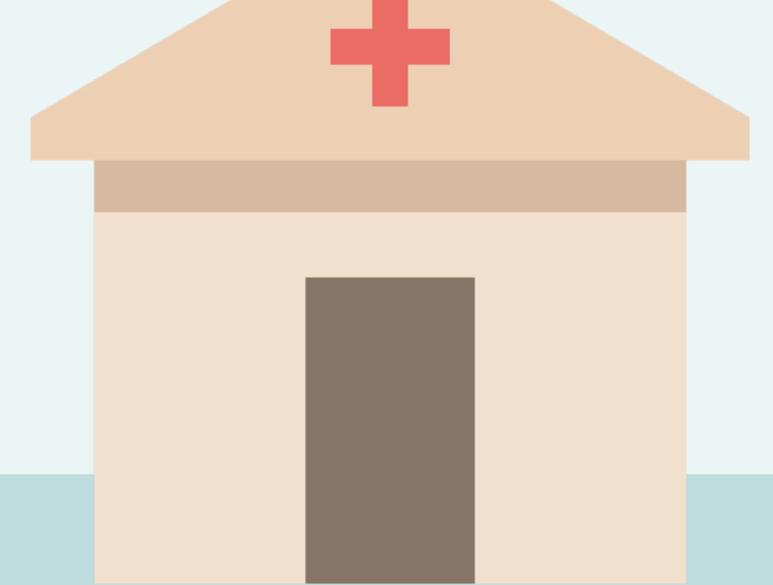
–Stakeholder interview, Elizabeth Bukusi, Chief Research Officer

STRUCTURAL ISSUES WITH THE HEALTHCARE SYSTEM EXACERBATES THE GAPS IN CARE



SERIOUS RESOURCE CONSTRAINTS

Health Care Workers face serious resource constraints, including staff shortages, heavy workloads, lack of supplies and inadequate infrastructure. However the degree of these constraints vary per delivery site.



1. RURAL VS. URBAN

While both rural and urban clinics lack resources and personnel, urban clinics are often far worse off.



2. PUBLIC VS. PRIVATE

Private facilities are regarded as providing higher quality emergency care but cost substantially more than government facilities

In one study:

- Women chose private over public facilities for family planning services due to the convenience and timeliness of services
- Women avoided public facilities due to long waits and disrespectful providers
- Women felt more confident about the technical medical quality in public facilities than in private
- Women reported that public facilities offered comprehensive counseling and chose these facilities when they needed contraceptive decision-support

3. HIV VS OTHER DISCIPLINE

Clinics that specialize in delivering HIV-related services often benefit from international funding and infrastructure.

However, only **67%** of facilities are ready to provide Kenya Essential Package for Health (KEPH) defined HIV and AIDS services.

“With continued scale-up of HIV interventions and in the absence of corresponding strengthening of service delivery structures, the quality of HIV services is compromised.” (KASF)

DISTRUST OF THE PUBLIC HEALTHCARE SYSTEM



TRUST OF THE HEALTHCARE SYSTEM IS LACKING

- There is a lack of trust in the care received at most public clinics; trust in private sector is not much better
- A lack of communication, planning and transparency may also be contributing to the lack of the trust between the healthcare system and the public
- There is a perceived inconsistency in the quality of care and availability of non-fraudulent medicines
- **11%** of people have reported paying bribes to public hospitals

“The health sector is characterized by unique risk factors and inherent complexities particularly susceptible to corruption, including information asymmetry, the large number of actors and mix of public and private sectors in healthcare systems, market uncertainty, and large amounts of public spending. These vulnerabilities allow the presence of various types of corruption: Bribery, kickbacks and informal payments to health personnel and administrators, fraud and abuse involving payments for healthcare goods and services that are not rendered, collusion and bid rigging in healthcare procurement and contract awards.” (standardmedia.co.ke)

<http://www.health.go.ke/wp-content/uploads/2016/04/Kenya-HRH-Strategy-2014-2018.pdf>

<https://globalhealth.duke.edu/media/blogs/diaries/finding-and-forging-trust-health-system-strengthening>

Transparency.org

<https://www.standardmedia.co.ke/lifestyle/article/2000228132/the-disease-of-corruption-hits-kenya-s-health-sector-hardest>

HIV COMMUNICATION

The National AIDS and STI's Control Programme (NAS COP) was established in 1987 to spearhead the Ministry of Health interventions on the fight against HIV/AIDS.

Seen as a credible custodian of information about health, campaigns from the MOH are functional in nature but use elements such as local icons, personal stories or entertainment to strike an emotional chord in their audiences.

In a nutshell, Kenya's HIV prevention programs focus on 3 aspects of behavior: Consistent condom use, limiting the number of sexual partners or staying faithful to one partner and sexual abstinence.



MTV SHUGA



Developed by [the MTV Staying Alive Foundation](#), MTV Shuga is an initiative that combines entertainment media, social media, print media, mobile (SMS and interactive voice response [IVR]), and live performance, bringing to the attention of young people (15-24) the social complexities of negotiating safer sexual and lifestyle decisions.



STRENGTHS:

- Used educational entertainment to weave in messages about HIV prevention etc. without coming across as preachy
- Converted TV educational entertainment messages into radio broadcasts broadening the program's reach
- Involved iconic youth champions in order to break through using popular music and stars as a draw
- Involved young people in the development of the content from the start, helping Shuga maintain local relevance and authenticity
- Reinforced, and facilitated dialogue about the edu-tainment content via peer educators

<http://www.prnewswire.com/news-releases/new-research-reveals-mtv-unicef-and-pepfars-ignite-campaign-has-altered-young-peoples-thinking-about-hiv-aids-attitudes-and-behaviours-98809589.html>
<http://www.comminit.com/global/content/mtv-shuga-multi-platform-communication-initiative-achieving-hiv-behaviour-change-adolesc>

RESULTS:

Soon after first season aired in 2009, John Hopkins University measured the intent to change behaviors after watching “Shuga” and found:

- Among a sample of 1,000 Nairobi youth, 60% had seen Shuga
- Those who saw the program could identify key lessons
- Over 70% of Nairobi youth viewer participants spoke to their peers and family members of Shuga characters and messages
- It affected thinking about concurrent partners, HIV stigma, and HIV testing in 80% of viewers
- Over 90% of Kenyan participants believed the show impacted their thinking
- Kenyan participants said they were more likely to take an HIV test after watching Shuga
- Attitudes toward stigma and HIV: intention to be friends with an HIV+ individual was 6.2/10 before the show and 7.7/10 after watching Shuga

CHAKRUOK



Entitled Chakruok (meaning ‘Beginnings’ in Dholuo), the radio soap opera, revolving around the life of a married adolescent girl, was aired on three FM stations in Nyanza province over an 8-month period.

STRENGTHS:

Text messaging and call-ins were incorporated to encourage listener participation and communication about the RH/FP and HIV issues raised in the episode concerned. A Facebook page was also set up for the listeners to explore the issues raised in the show in more detail. Several times a week, different questions were posted on the Facebook page to encourage discussion and debate.

RESULTS:

- Increased uptake of family planning (FP) methods
- Increased support of the partners for married adolescent girls to access reproductive health (RH) services
- Increased attendance of antenatal care visits
- Increased use of post natal care visits
- Increased uptake of HIV testing among never pregnant married adolescent girls



VOLUNTARY MEDICAL MALE CIRCUMCISION PROGRAM



The MOH launched the National VMMC program aimed at circumcising **860,000** men (**80%** coverage) aged 15-49 by the end of 2013. As part of its implementation strategy, over 3,000 service providers were trained and journalists were educated about the science and benefits of VMMC as HIV prevention. They utilized mass media like radio spots, signage, and interpersonal communication such as training and working with community mobilizers.

IMPLEMENTATION MEASURES CRITICAL TO SUCCESS:

Education of journalists to ensure positive perception of VMMC, consultation with community gatekeepers, sensitization of HCW

RESULTS:

- Between 2008 and 2013, annual operations increased from **8,000 to 190,000** (**71%** coverage) out of its intended **80%** target
- Surpassed its coverage goal of the Nyanza Region with **474,000** VMMC procedures

LESSONS LEARNED:

- Task shift VMMC services to nurses and add mobile and moonlight services to increase access.
- Next phase of program aims to see **95%** of men aged 15-49 years circumcised by 2019.



TEXT IT



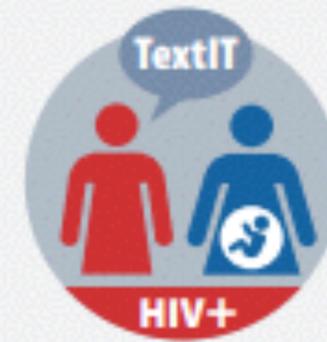
The Kenya Medical Research Institute launched the TextIT campaign to improve HIV testing and prevention. TextIT is an interactive text message program for HIV-positive pregnant women in the Nyanza Region of Kenya. It's goal was to encourage them to test their infants for HIV.

STRENGTH:

Mothers living with HIV were trained and employed as part of the medical team to support pregnant women about their health and their babies' health.

RESULTS

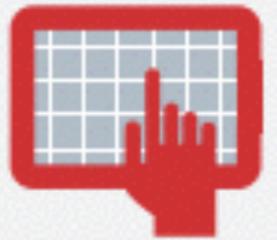
- Research conducted prior to formal TextIT implementation found that women who received the messages were more likely than other women to visit postpartum clinics and have their babies tested for HIV
- Interim results found that in the SMS group, **20%** women attended maternal postpartum clinics compared to **12%** of the non-SMS group



KEMRI uses mentor mothers to inform pregnant women who are living with HIV about the TextIT service



Pregnant women receive encouraging educational messages and can send SMS or call at any time



Web-based dashboard allows health-care providers to track pregnancy status

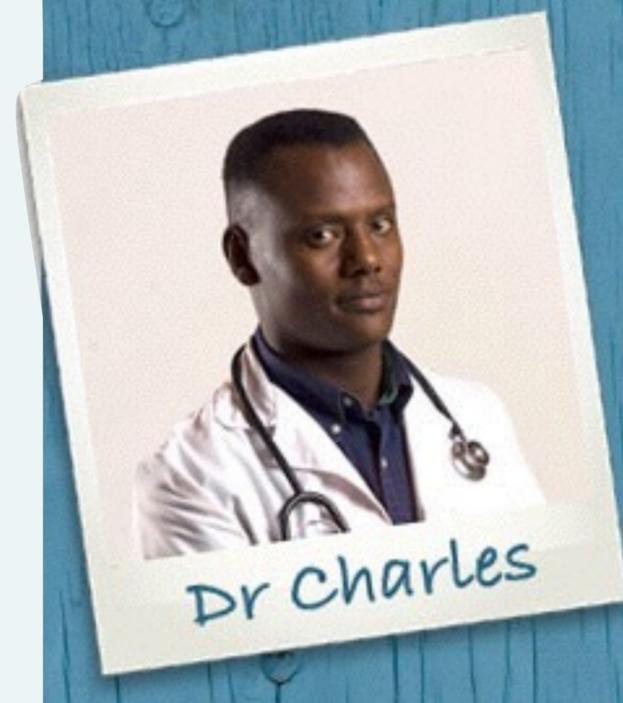


TextIT staff send SMS or call women to check date of delivery, then update the server with infant details for personalization of postpartum SMS service



TextIT sends out personalized SMS reminders to attend postpartum clinics and have their infants tested for HIV

DANYA MAKUTANO JUNCTION



MOH sponsored a Danya partnership using the Makutano Junction storyline, a soap opera, to disseminate messages about TB and HIV prevention testing. It promoted cross-testing for TB and HIV and raised awareness of connection between HIV and TB amongst those with TB and/or HIV and their families. The campaign used television, SMS, print, and radio to reach health care workers, HIV and TB patients, their families, and the general public. Health Care Workers were targeted to counter stigma and raise awareness about their own HIV status. This campaign was praised for its high impact and utilization of technology and media.

RESULTS

- Number of people citing Makutano Junction as raising awareness for HIV and TB increased from **26%** to **65%**
- **92%** of respondents stated Makutano Junction's information about TB and HIV influenced change in their behavior
- Awareness of TB/HIV relationship from television increased by **7%**

ALL IN CAMPAIGN



The international movement/campaign, known as ‘All In,’ and sponsored by the likes of PEPFAR, UNAIDS and others, seeks to mobilize different stakeholders globally to commit towards halting the spread of HIV and AIDS amongst young people, especially adolescents and hopes to reduce stigma. Its goals are to decrease AIDS related deaths by **65%** and new HIV infections by **75%**, and achieve zero discrimination by 2020.

A screenshot of the ALL IN website homepage. The header features the 'ALL IN' logo with a red and blue globe icon and the hashtag '#EndAdolescentAIDS'. A navigation menu includes 'HOME', 'WHY', 'WHAT', 'LIFE STORIES', 'SOLUTIONS', 'TAKE ACTION', 'IATT-YP', and 'ENGLISH'. The main content area has a teal background with silhouettes of raised hands. A red box labeled 'What' is positioned above the text. The text reads: 'It's time for us to **take action.** **ALL IN** is about bringing everyone together to stop adolescent **deaths, infections** and **violence** caused by **AIDS.** So, whether you're a teen, a parent, a health professional, an activist, HIV+ or not, this is **our reality.** We are **ALL IN** this together.'

RESULTS

- Campaign is still in progress
- From President Kenyatta's speech Sept 2015:
 - Over **80%** adults in need for ART were reached, but less than half were adolescents
 - Initiated more than **800,000** Kenyans on lifelong medication

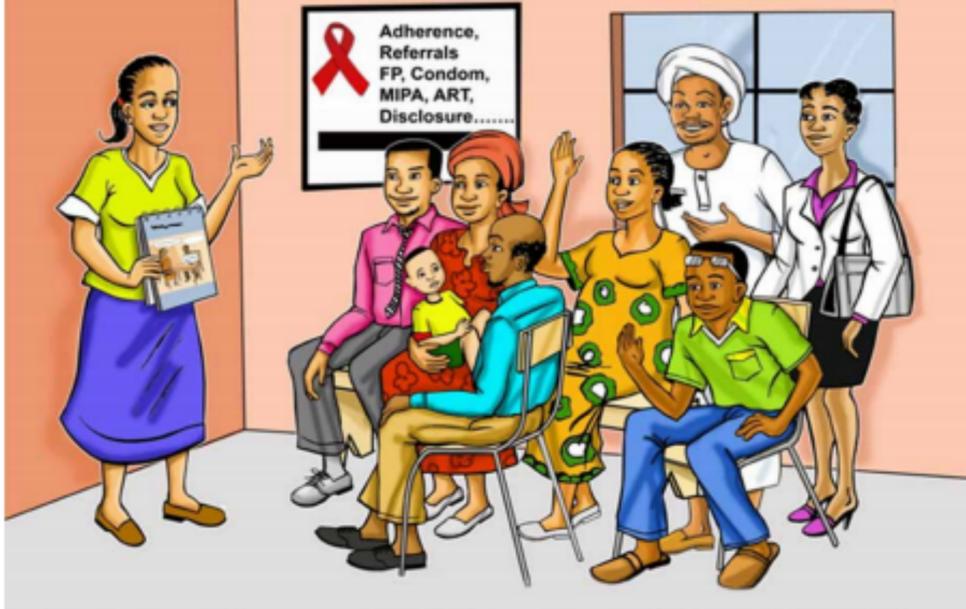
PREVENTION WITH POSITIVES (ONGOING)

Intervention targeting PLHIV and at risk of transmitting the virus, including HCW, spreading the message of condom use and healthy life habits. Utilizes peer workshops and focus groups, one-on-one transmission risk counseling, HIV+ support groups, psychosocial assessments and support, and promotes 13 key prevention messages.

The trend is now shifting towards “Positive Health, Dignity and Prevention” (PDP) terminology instead, which has a broader focus that includes health and dignity.



MINISTRY OF HEALTH



PREVENTION WITH POSITIVES
National Orientation Package for Managers and Supervisors

Accelerating Prevention among people living with HIV through Positive Health & Dignity

The complex block features the Ministry of Health logo at the top center. Below it is an illustration of a health worker in a yellow shirt and purple skirt standing and talking to a group of diverse people seated in a room. A sign on the wall lists 'Adherence, Referrals, FP, Condom, MIPA, ART, Disclosure.....'. The title 'PREVENTION WITH POSITIVES' is in large blue letters, followed by the subtitle 'National Orientation Package for Managers and Supervisors' in smaller blue letters. At the bottom, a tagline reads 'Accelerating Prevention among people living with HIV through Positive Health & Dignity'.

RESULTS:

None available.

NATIONAL HIV PREVENTION MEDIA CAMPAIGNS: POTENTIAL GAPS

Given the research and insights gathered regarding our audiences, the following HIV prevention messages can be prioritized above ‘abstinence’ and ‘staying faithful’ to one partner:

- The importance of consistent and correct condom use (even with a ‘regular’ partner*)
- How rarely condoms are actually used*
- Education around the risks of multiple and concurrent partnerships or sexual encounters
- The importance of delaying sexual debut
- Education to dispel misconceptions and rumors regarding how HIV is transmitted, and how it can be “cured” or “removed from the body”*
- How alcohol and drugs lead to sexually risky behaviors
- Real life stories about people living with HIV, people using ARV’s, people using PEP, people using PrEP etc.*
- Campaigns increasing awareness that even though PLHIV can live long and healthy lives on ARV’s, the better life is to be HIV-free
- Campaigns humanizing FSW, MSM and PWID*
- Campaigns normalizing SRH and healthy sexual responsibilities of AGYW*

* Potential gaps/areas of opportunity among vulnerable populations

EVIDENCE-BASED BEHAVIOR CHANGE INTERVENTIONS (INTERPERSONAL CAMPAIGNS)

SHUGA

This is an HIV prevention intervention that targets in- and out-of-school youth aged 15–24 years. It is a three part drama series which seeks to increase the risk perception of youth to HIV infection, increase uptake of HTC/VMMC services, increase knowledge on HIV prevention strategies including partner reduction and STIs screening and treatment. After screening each of the three episodes, a pair of trained peer educators uses the discussion guide to facilitate an interactive session that lasts 30-45 minutes, with 15-25 youth participating. Since July 2010 when we introduced the intervention, 46,322 in- and-out-of school youth have been reached.

HEALTHY CHOICES II

This is a community–based group level intervention for adolescents aged 13-17 years. The curriculum focuses on raising awareness about the risks they face, improving sexual safety by identifying risky settings and enhancing communication and negotiation skills. The curriculum is delivered through a series of 4 consecutive weekly sessions covering 2 modules in each session lasting 2-2½ hours. A group comprises of 16 youths, trained by a pair of facilitators (male and female). So far 28,051 in-and-out of school youths have been trained since September 2009

STEPPING STONES

This is an approach to HIV prevention that aims to improve sexual health through building stronger, more gender-equitable relationships with better communication between partners. It uses participatory learning approaches to build knowledge of sexual health, awareness of risks and the consequences of risk taking, communication skills, and provide opportunities for facilitated self-reflection on sexual behaviour.

The intervention is delivered through 2½-3 hour sessions per week for 8 weeks, by a pair of trained facilitators. The intervention was introduced in January 2011, and so far, 12, 073 male and female fisherfolk have been reached.

PROJECT RESPECT

This project utilizes a ‘teachable moment’ to motivate clients to change risk-taking behaviours, by exploring the circumstances and context of recent risk behaviour. The intervention is delivered to MSM, FSWs, PWIDs, fisherfolk through the existing programs including HTC and clinical rooms where discussion of client risk and risk reduction strategies occur.

SISTER TO SISTER (S2S)

The intervention aims to provide one-on-one intensive, culturally sensitive health information to empower and educate women in a clinical setting; help women understand the various behaviours that put them at risk for HIV and other STIs; and enhance women’s knowledge, motivation, confidence, and skills to help them make behavioural changes that will reduce their risk for STIs, especially HIV.

KNOWLEDGE GAPS: CATEGORY

How will the devolution of the health care system impact the distribution of PrEP?

CONNECTIONS

Our understanding of how consumers interact and influence one another, as well as the impact from other sources.

LTURE

MPANNY

CONNECTIONS THEMES

RADIO IS STILL CRITICAL

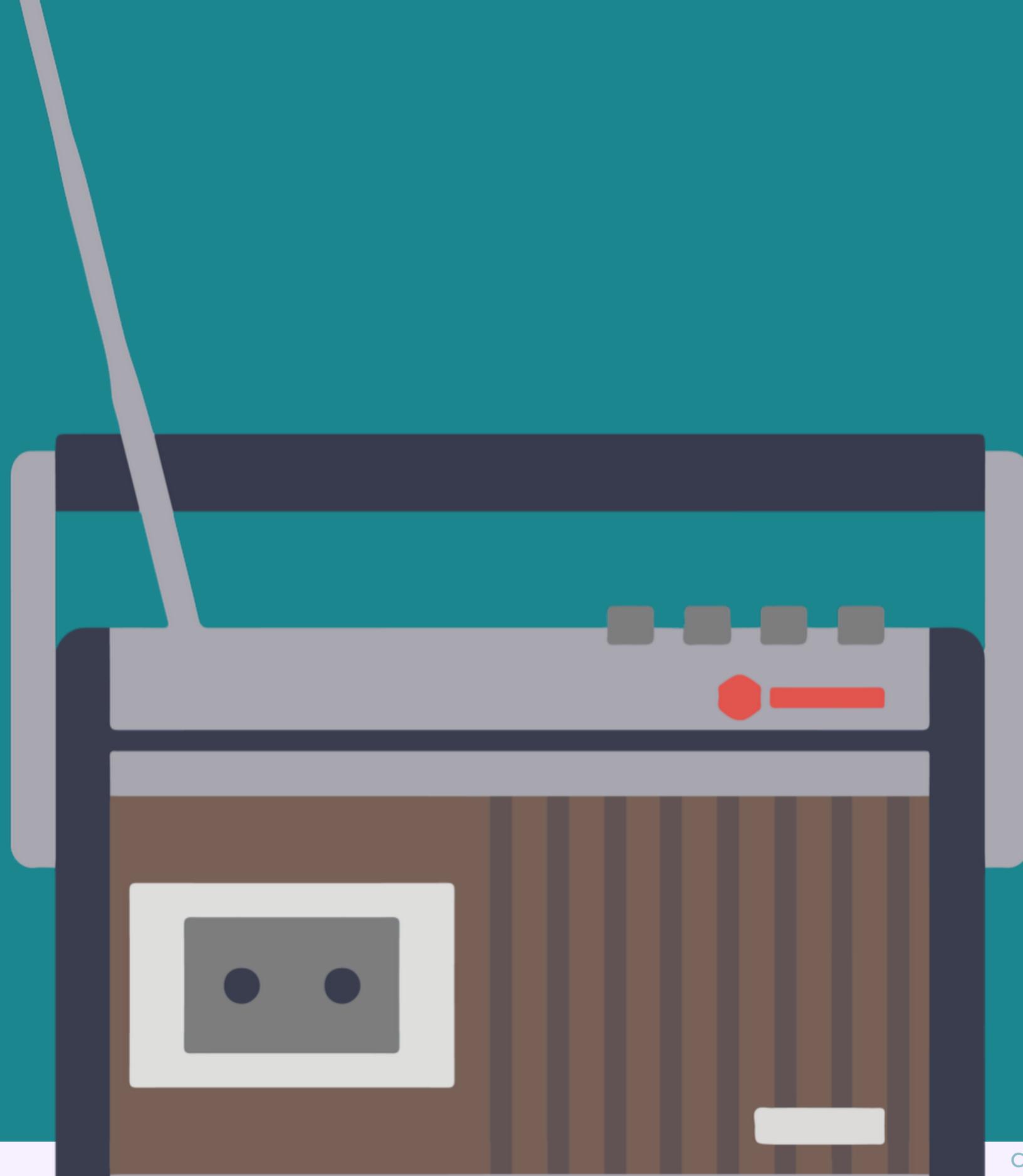
THE RISE OF INTERNET

MAJORITY CONNECTED VIA MOBILE

OTHER OPPORTUNITIES TO REACH KEY POPULATIONS

SPECIFIC AUDIENCE INSIGHTS

RADIO IS STILL CRITICAL



RADIO CONTINUES TO DOMINATE AND BE THE MAINSTAY OF NEWS CONSUMPTION

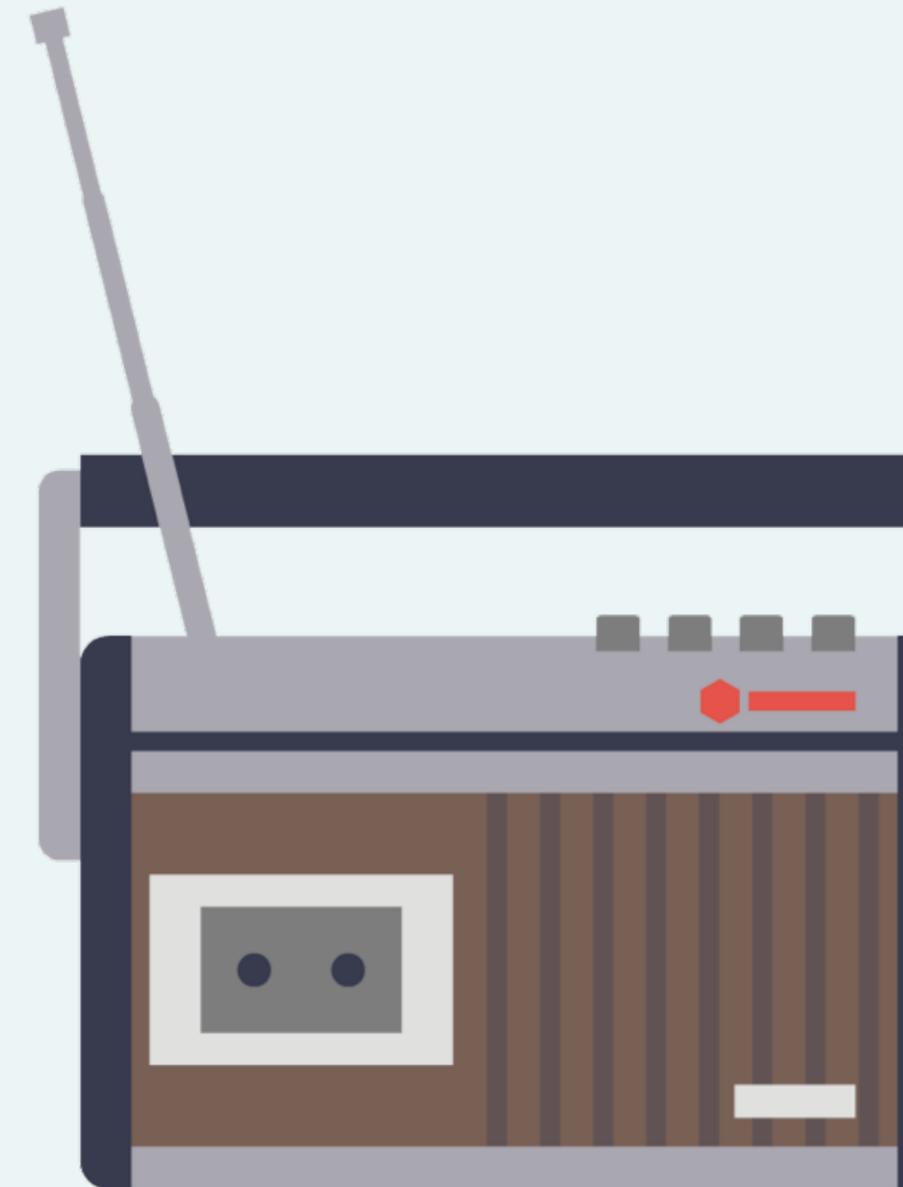
74% of Kenyans have access to the country's 120 radio stations

There is a rising number of radio stations, especially community and FM stations (mostly local-language radio, popularly referred to as “vernacular radio”):

- **70%** of radio audiences listen to Swahili stations
- **68%** of radio audiences listen to vernacular stations
- **52%** of radio audiences listen to English stations

Vernacular radio audiences spend at least **three hours per day** listening to the broadcasts

These have gained in popularity because people believe that the community media directly addresses the concerns of the audiences

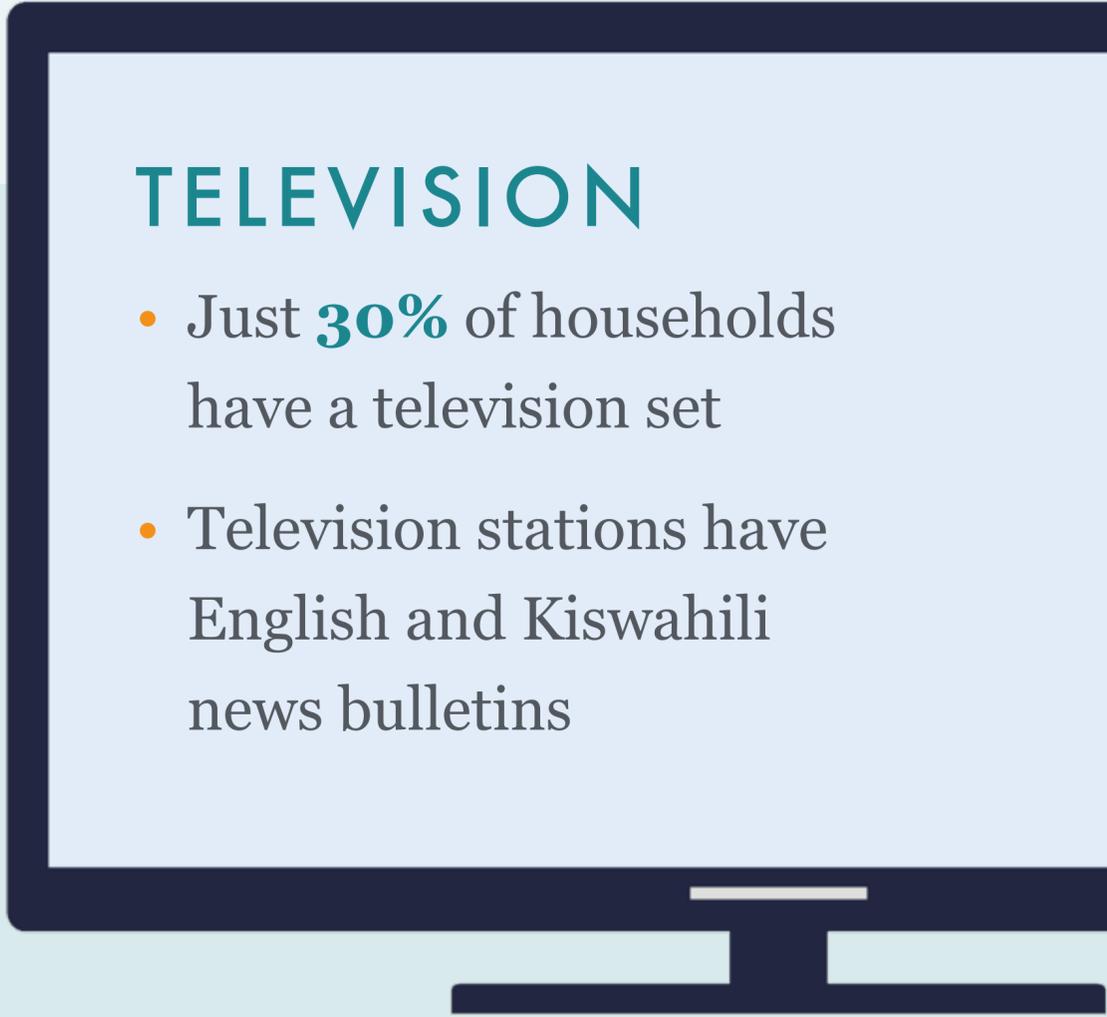


OTHER TRADITIONAL MASS MEDIA CHANNELS ARE USED LESS



NEWSPAPERS

- Printed newspaper circulations are falling or stagnating
- **3 million** Kenyans read a newspaper every day
- Growing out their online presence as internet use increases



TELEVISION

- Just **30%** of households have a television set
- Television stations have English and Kiswahili news bulletins

A stylized, light grey mobile phone icon is positioned on the left side of the page. It features a circular camera lens at the top, a large rectangular screen in the center, and a small horizontal bar at the bottom representing a home button. The phone is oriented vertically.

MAJORITY CONNECTED VIA MOBILE

MOBILE PHONES ARE A KEY WAY KENYANS CONNECT WITH EACH OTHER AND THE WORLD

NEARLY 4 OUT OF 5 KENYANS HAVE A MOBILE PHONE

- **78%** of people own a mobile phone
- Women, the less educated, and those who cannot read less likely to own a phone
- Very few use a landline **~3%**
- Texting is the most common use of cell phones

RISING OWNERSHIP OF SMARTPHONES

- Highest ownership among younger, educated and English speaking
- **15%** of population own a smartphone

PHONES ARE SHARED

- **21%** of Kenyan mobile phone owners said they share their phone with someone else

INNOVATIVE MOBILE SERVICES

- Used for mobile banking, m-health, m-commerce, gaming

MOBILE PHONE OWNERSHIP AND INTERNET ACCESS ARE INCREASING: USE SOCIAL TECHNOLOGY TO EDUCATE AND SPREAD HEALTH MESSAGES

RISING USE OF E-LEARNING & M-HEALTH

E-learning through tablets and educational, web-based material is a growing way of reaching children, particularly in hard-to-reach rural areas

Mobile apps are being used to educate about public health issues

YOUNG AFRICA LIVE

Young Africa Live enables young people to talk about topics that affect their daily lives including sex, HIV, rape and gender issues, as well as where to get tested for HIV. The platform now has 1.8 million users across South Africa and is expanding to Tanzania and Kenya.



THE RISE OF INTERNET



NEW FORMS OF CONNECTIVITY ARE EMERGING, DUE TO RISE OF INTERNET USE

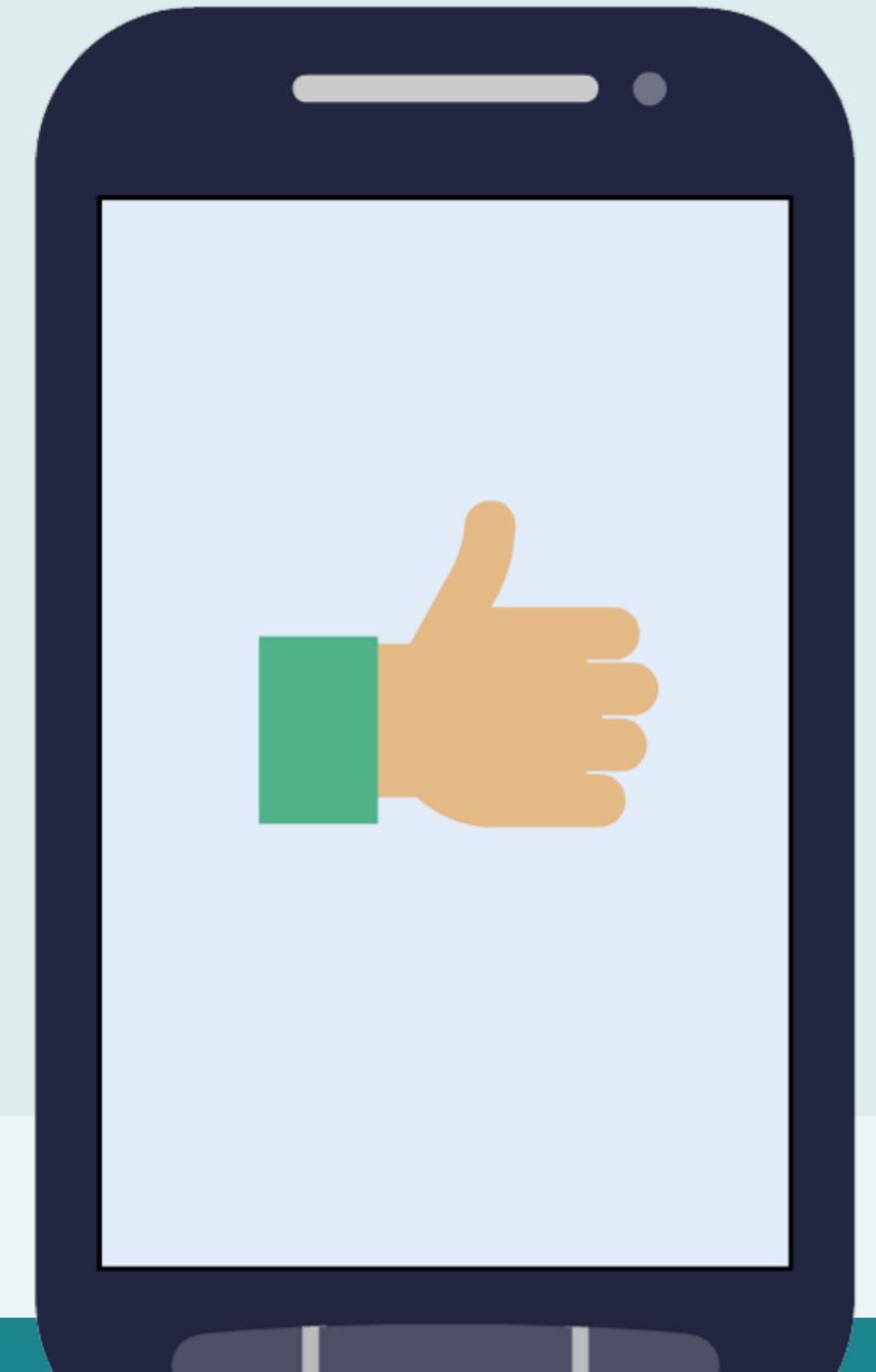
GROWTH IN INTERNET PENETRATION IN KENYA

- **99%** of Kenyans access the internet from their mobile phones (Communications Commission of Kenya)
- There are **23 million** internet users (approx. **55%** penetration)*

SOCIAL MEDIA

- About **4,000,000** Kenyans use social media
- **21,300** new **Facebook** accounts are created every three months.
- **49%** of mobile users use **WhatsApp** as their primary messaging tool

Most popular among young people however worth noting that during the LVCT Health's PrEP demo project, the most at-risk youth were not on social media; they needed an anonymous platform to ask questions.



*Quarterly Sector Statistics Report: First Quarter of the Financial Year 2014/15**

*Kenyan company makes business sense of Whatsapp, eyes global market (CIO, 2014)
End-User Landscape Mapping, HIV PMM, AVAC, published Jan 2017
June 2014 data - [State of Social Media in Kenya](#)*

OTHER OPPORTUNITIES

PEER EDUCATORS

Kenya's NASCOP has developed a toolkit for male and female community outreach workers (peer educators) consisting of a reference manual, a training manual, and a participant notebook (not currently available online). The toolkit uses simple language and drawings. The manual consists of seven modules.

1. Peer educators: Who we are and what we do
2. All we need to know about HIV, STI, and sexual and reproductive health
3. How to prevent HIV and STIs
4. Knowing our HIV status: promotion of HIV counselling and testing
5. Planning our future
6. Creating an environment for behavior change
7. Recording and reporting our progress

Peer = A person who shares almost the same characteristics with another, such as age, social status, sexual orientation, etc. E.g. adolescent girls in a village of the same social status and educational level.

Peer education is based on the reality that many people make changes not only based on what they know, but on the opinions and actions of their close, trusted peers. Peer educators can communicate and understand in a way that the best-intentioned non-peers can't, and can serve as role models for change. Note that peer education is not exclusively for school-based programs, but has been used in a wide range of contexts with a diversity of populations, including street youth, factory workers, sex workers, drug users, prisoners, etc.

Some of the ways they are doing this in schools around the world include:

- Leading informal discussions
- Video and drama presentations

- One-on-one time talking with fellow students
- Handing out condoms, leaflets and brochures
- Offering counselling, support and referral to services.

The MOH has developed guidelines for peer educator and outreach programs.

Ex. BHESP has used peer educators to reach over 22,000 sex workers. Every peer educator works with between 40 and 80 sex workers by first mapping out their hot spots, then helping them access health care, condoms, SRH information, and also helping them address legal issues such as arrest, harassment and violence.



PrEP CHAMPIONS/AMBASSADORS

- People from within high-risk communities who can identify peers who might benefit from PrEP
- Potentially on PrEP themselves but not necessarily
- Champions are encouraged to set up private meetings in which they lay out the benefits of PrEP. However, other ways are also used to connect:

“I will send you a text message to remind you to take PrEP. I will post sexy pictures of me taking PrEP, share articles about it online.”

—Stakeholder Interview, Brandon Kimani, PrEP Ambassador

EXAMPLES OF PREP CHAMPIONS/AMBASSADORS INCLUDE:

- Peer educators within key populations
- Pharmacists who provide the emergency family planning pill and who can advocate the benefits of PrEP during this interaction
- People living with HIV who can who can talk to the fact that they wish they could have taken advantage of PrEP before it was too late.

Brandon Kimani is both a male sex worker and from the MSM community. Brandon has always been responsible about his SRH, so when he first heard about PrEP, he knew it could be beneficial for him in terms of protecting him from HIV. As a peer educator for LVCT Health he also knew that he could be helpful in spreading knowledge about it. Once trained by LVCT Health on PrEP, what it is, what it does, who it's for and how to mobilize people, he now uses that training in combination with his personal social media channels to help get the message out there. So far he has had great success—so much so that he was named Kenya's PrEP User of the Year in 2016.



LOCAL CHAMPIONS/ CELEBRITIES

Local champions and/or local “celebrities” can be effective in obtaining the community’s buy-in. For example, in one LVCT Health PrEP demo project, community local boys said that PrEP is a pill for “promiscuous girls.” The project worked to get the buy-in of several male champions and paired them with girls, with more success.

In another community the local “celebrity” was the older women.

FGM-ERADICATION PROGRAMS

1. MAENDELEO YA WANAWAKE (MYWO) ALTERNATIVE RITE OF PASSAGE PROGRAM

(However, MYWO is currently under a forensic audit)

2. FULDA-MOSOCHO PROJECT

(Unclear if this project is still on-going): The goal of the Fulda-Mosocho Project, in dialogue and in cooperation with the Kisii, is to improve the physical and emotional living conditions of women. Social education workers from Fulda who run the education programs address the physical and psychological effects of FGM, touch upon gender relations, and also cover gender education, family planning, and AIDS prevention.

fulda-mosocho-project.com
fgm-c.info/ong/tasaru-ntomonok-initiative
popcouncil.org
<http://mywokenya.org/>

3. THE NTOMONOK INITIATIVE (TNI)

Tasaru Ntomonok Initiative (TNI) is a community-based organization in the Southern Rift Valley, Narok District of Kenya, founded by Agnes Pareyio in September 1999. TNI works within the Maasai culture and surrounding community to eradicate the practices of Female Genital Mutilation (FGM) and early childhood marriages by educating girls and their families. It has established the Tasaru Rescue Center by providing a safe house to assist girls attempting to escape the practices.

4. THE YWCA

The Young Women's Christian Association has been implementing programmes encouraging the abandonment of FGM in Kenya since 2006. Programmes focus on three regions where the prevalence of FGM is high: Meru, Kisii districts, and among the Masai in the Kajiado district. An Alternative Rites Approach (ARP) approach has been adopted among the Meru and the Kisii, with short events focusing on education, rights, career choices, and the adverse effects and complications of FGM. The week-long camps end with an ARP ceremony, to which community leaders and parents are invited. Among the Masai, the YWCA has established rescue centres which also offer training in combating the stigma of non-circumcision, and raising awareness about FGM. In all three areas, the YWCA works with local schools, parents, and religious and community leaders, in addition to the ARP and rescue camps. Anecdotal information from YWCA indicates that considerable progress has been made in changing attitudes in relation to FGM among the Meru where the programme has been implemented since 2006. The programmes among the Masai and Kisii are more recent, although signs of increased abandonment in the two communities have been observed.

HIV PREVENTION SERVICES

- HIV Testing and Counseling
- STI Screening and Treatment
- TB Screening and Referral to Treatment
- HIV Care and Treatment
- Promotion, Demonstration and Distribution of Male and Female Condoms and Water-Based Lubricants
- Family Planning and Sexual and Reproductive Health Services (being able to access PrEP and FP services at one place is key for AGYW)*
- Post-Abortion Care Services
- Cervical Cancer Screening
- Emergency Contraception
- Post rape care
- Screening and management of hepatitis B
- Opiates substitution Therapy
- Needle exchange program
- Male Circumcision

Products like emergency contraception and PEP are more sought after on Monday and Tuesday, right after the weekend.

WHERE PEOPLE ACCESS PEP

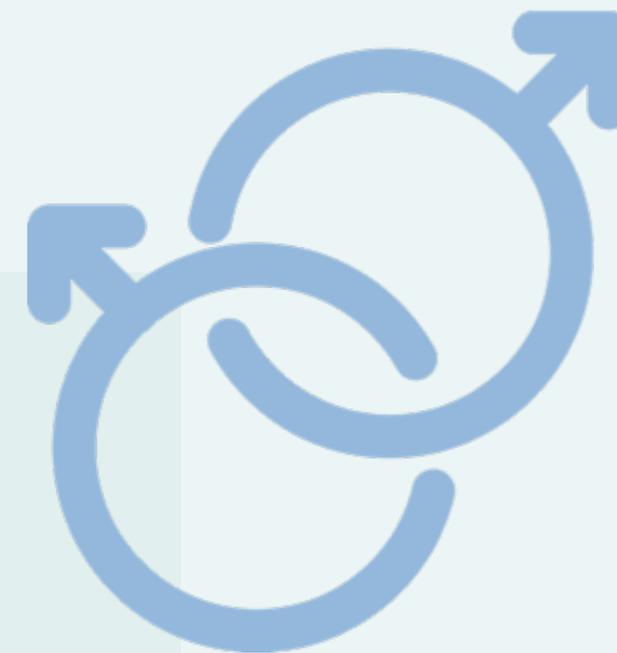
“...there has been a sharp rise in the number of people seeking the drugs after engaging in unprotected sex, especially during holidays and weekends. Many of those asking doctors to give them the pills use them in the same way others use emergency contraceptives—as an afterthought.”

—nation.co.ke

SPECIFIC KEY POPULATION INSIGHTS



MEN WHO HAVE SEX WITH MEN



THEIR INFLUENCERS

- Exist in closed groups for fear of rejection, stigma and victimization
- Get support from support groups and associations, e.g. MAAYGO, GALCK, Ishtar, National Gay and Lesbian Human Rights Commissions
- Eric Gitari: leader gaining prominence in urban areas like Nairobi
- National AIDS Control Council, run by Kenyan government
- NASCOP which handles biomedical services for MSM

SOURCES OF CREDIBLE SRH INFORMATION

- Selected clinics that have young and understanding health workers, doctors, and counsellors
- Peer-driven programs and trusted health providers at “MSM-friendly” clinics
- Information mostly goes through MSM associations (e.g GALCK and ISHTAR training, empowerment activities, LVCT Health, ICRH, etc.)

“There is a world of MSM organisations doing incredible things. In Nairobi, MSMs get information from Ishtar and HOYMAS, in Nakuru they get information from KYDESA, in Eldoret they get information from Q-Initiative, in Mombasa they get information from HAPA KENYA, PEMA KENYA, TAMBA PWANI, UKWELI.”

–Brian Macharia, GALCK

MEN WHO HAVE SEX WITH MEN

THEY CONNECT ONLINE

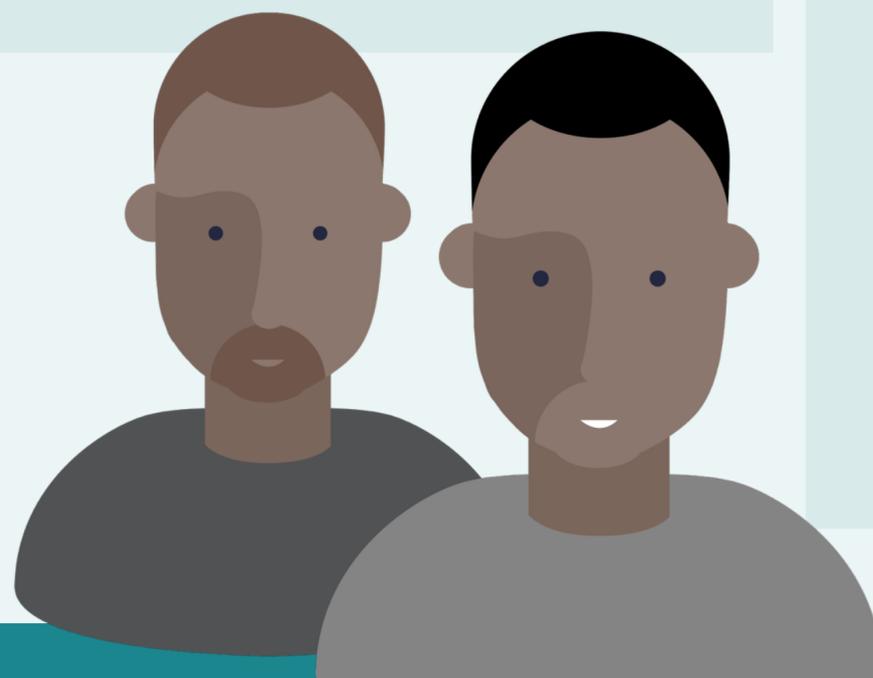
If not meeting each other offline, at hot spots or house parties, the MSM can meet each other online on dating and cruising sites e.g. Grindr, PlanetRomeo, etc.

THEY MEET AT DROP-IN CENTERS

Ex. MSM regularly come into drop-in centers for condoms, lubricants, counselling, and testing.

ORGANIZATIONS SUCH AS MAAYGO USE MULTICHANNEL COMMUNICATIONS OUTREACH

- Increased focus on peer-driven, behavior-change communication through nontraditional outreach programs e.g. in nightclubs, hotels, and bars frequented by MSM.
- Facebook, WhatsApp, and other mobile engagement methods are used to maximize attendance at clinics, and secret passwords are used to enable MSM to access specialist services in mobile clinics without fear of discovery.
- MAAYGO also hosts a weekly radio show on Radio Osienala that explores issues related to MSM. The 50-minute show is a lively, educational, and entertaining programme delivered in Dholuo, the main language of western Kenya.



<http://www.mtvstayingalive.org/blog/2016/05/what-is-it-like-being-gay-in-kenya/>

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MEN WHO HAVE SEX WITH MEN

MSMs TRUST PEER EDUCATORS AND PEER OUTREACH PROGRAMS

THE PEER EDUCATOR MODEL IS CRITICAL

“The peer model is a very celebrated approach; [it is] fast and effective for MSM’s because of the way in which the behavior is criminalized. [They are] more inclined to receive information from someone they trust and who they [can] connect with.”

–Stakeholder Interview, Brian Macharia, GALCK

HOW IT WORKS

*“Every organization has their own peer outreach program which **involves assessment of needs** and identifying hotspots then they hire peer educators who can then disseminate information. [For example,] over 6 GALCK organizations have this program.”*

–Stakeholder Interview, Brian Macharia, GALCK

NOT WITHOUT LIMITATIONS

*“There has been some limitations to these peer outreach programs. The peers were **originally managing a region** but it wasn’t working so well. **Now peer educators are in charge of about 40-50 men** that they are personally responsible for. This is only happening in Nairobi right now.”*

–Stakeholder Interview, Brian Macharia, GALCK

ADOLESCENT GIRLS AND YOUNG WOMEN

THEIR INFLUENCERS

Being in a self discovery phase, behavior is usually driven by peers, especially those in urban areas. Additionally, role models—who range from parents, teachers, and celebrities—also influence their behavior. In some parts of rural Kenya, the influence of aunts and grandmothers is also heavy.

THEIR SOURCES OF SRH INFORMATION

- Mostly from social media (urban-skewed): for the rural folk, information is received from their aunts/extended relatives or friends.
- Information considered most credible is that which is relayed through role models, health workers/doctors, or that which is endorsed by their teachers
- Some churches/religious organizations have formed numerous forums that target adolescents e.g. hikes/getaways/boot camps organized by churches where youths can freely interact and learn about SRH. E.g. AFLEWO, Youth Alive conferences



ADOLESCENT GIRLS AND YOUNG WOMEN

Other ways to potentially reach this audience:

HEALTH FACILITIES AND YOUTH CENTERS:

The consensus is that providing a wide range of SRH services in either integrated health facilities or youth centres is more likely to ensure that anonymity and that privacy could be maintained. Also, communication activities involving events, mentoring, and youth-centres have had a largely positive impact on the knowledge and attitudes of this group.

GIRL TALKS:

Girls also mention having *girl-talks, girls-days, and “things to do with beauty”* as a way of attracting girls.



VIA MESSAGES SPREAD BY THE MOH/NASCOP:

As part of the recommendations of the Fast Track Plan to End AIDS Among Adolescents, Annual HIV and Health Education Days were observed in each school, and HIV messages were integrated into school books, school stationery, teachers materials, and county town-hall meetings.

SERODISCORDANT COUPLES

THEIR INFLUENCERS

Trusted health workers or testimonials from other serodiscordant couples are considered credible.

THEIR SOURCES OF SRH INFORMATION

- Information gets to them through workshops organized by health workers/clinics
- Information that is endorsed by health practitioners is deemed as credible



SERODISCORDANT COUPLES

EFFECTIVE INTERVENTION STRATEGIES TO REACH MEN TO DISCUSS SEXUAL AND REPRODUCTIVE HEALTH COULD POTENTIALLY INCLUDE:

- Male educators travelling door-to-door to disseminate information specifically for men
- Male outreach workers viewed as more trustworthy
- Men's barazas (community meetings held by village leaders)
- Churches, schools, funerals, microfinance groups, football matches



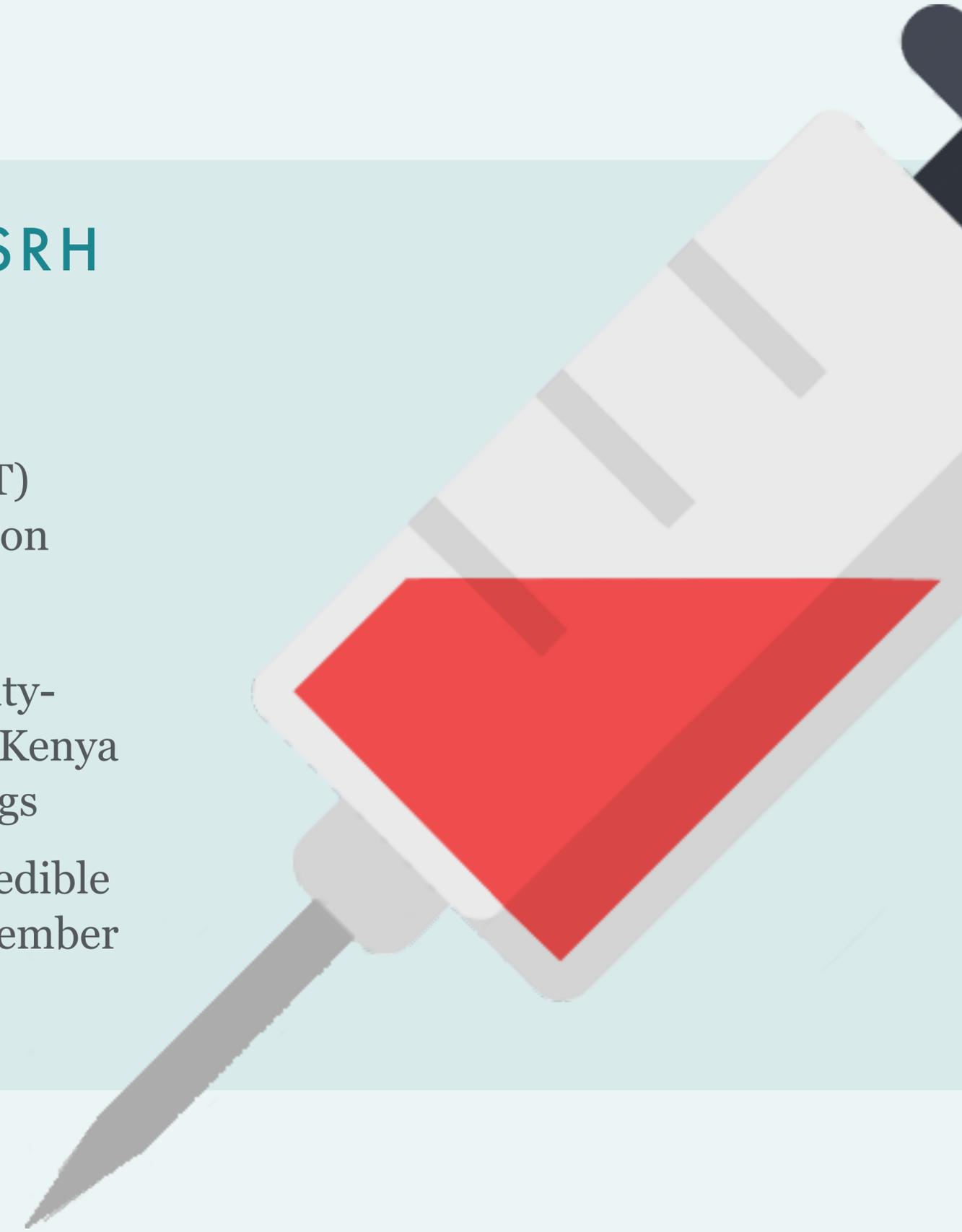
PEOPLE WHO INJECT DRUGS

THEIR INFLUENCERS

They are usually motivated by peers. Anyone known to have a link with their drugs qualifies to be a friend.

THEIR SOURCES OF SRH INFORMATION

- Peer educator programs
- Medically assisted therapy (MAT) programs to reduce drug addiction
- Harm reduction programs
- Support networks and community-based organizations such as the Kenya Network of People who Use Drugs
- Information considered most credible is that which is endorsed by a member of their community



FEMALE SEX WORKERS

Contraceptive service delivery in Kenya: A qualitative study to identify barriers and preferences among female sex workers and health care providers (March 2016)

** IBBS Survey among migrant female sex workers in Nairobi, Kenya. 2010*

*** Stakeholder interview, Grace Kamau, KP Consortium*

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[AIDS 2014: Peer programs engage injection drug users in Kenya and Tanzania](#)

[Avert.org](#)

OPERATE AT NIGHT

Many street-based sex workers are working most of the night and sleeping during the day.

Alternative HIV outreach times and locations are necessary for sex workers.

INTERNET SAVVY SEX WORKERS ARE MOVING ONLINE

Through sites such as Nairobiiraha.com, Nairobiitamu.com, and Nairobiescort.com

SOURCES OF SRH CARE AND INFORMATION

- Receive care from both public and private healthcare facilities, and CBO-provided clinics like that of Bar Hostess, LVCT Health, and SWOP
- Research has indicated that the most appropriate person to deliver information about STI/HIV is an older female followed by a female of the same age*
- The preferred place to receive such information is hospitals (**70%**), followed by TV (**8.2%**) and community health workers (**7.5%**)*
- Drop-in centers are also preferred
- Peers and peer educators give advice on safe sex, condoms and information related to HIV testing (prevention initiatives that involve sex workers educating their peers has led to increased protected sex and reduced HIV prevalence)
- Community-based organizations such as KEWSA, BHESP, etc, who pass on information and provide trainings and empowerment activities
- Where they procure condoms: public health facilities, CBO's like BHESP, pharmacies, shops, supermarkets, or clubs

LOOKING FOR SAFE SPACES THAT SUPPORT THEM IN FACING THEIR RISKS AND CHALLENGES

Ex. Social groups:
“(Called) Merry Go Rounds. It is a social gathering (where) we contribute some money and every week, the money goes to one sex worker. We help fellow sex workers cover the expenses e.g. sending their child to school; buy cutlery, that sort of thing.”**

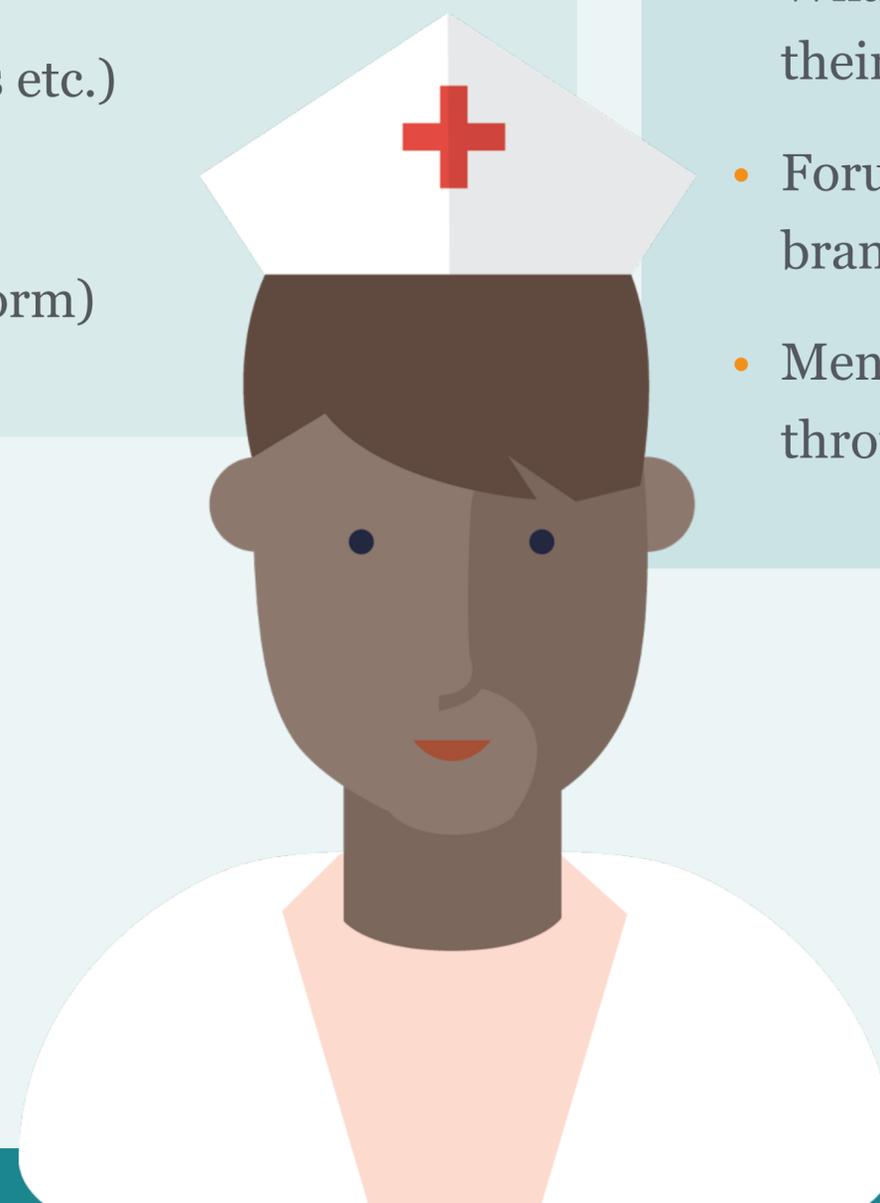
HEALTH CARE WORKERS

CAN RECEIVE INFORMATION RELATED TO HIV PREVENTION PRODUCTS AND SERVICES IN DIFFERENT WAYS

- NASCOP (Guidelines, National training of trainers etc.)
- Continuous Medical Education (CME's)
- National HIV Integrated Curriculum (online platform)

HOW HCW'S CONNECT WITH EACH OTHER

- Whatsapp groups e.g. Pharmacies have their regional groups on Whatsapp
- Forums held during CME's (which can be brand-sponsored)
- Mentoring system that is prevalent throughout the health care system



KNOWLEDGE GAPS: CONNECTIONS

- Need further detail as our audience's influencers, including healthcare workers. Who do they look up to? Who do they respect on an individual, community and public level?
- How and to what extent can religious leaders help spread the message about PrEP as part of an effective combination prevention strategy?
- Need to better understand our audience's consumer journey in coming to the decision that PrEP is right for them.
- To what extent and how do religious leaders influence our audiences when it comes to making decisions about SRH and protecting themselves from HIV?

COMPANY

The product, organization or offering (PrEP), and the perceptions surrounding them.

COMMUNEC

CATEG

COMPANY



PrEP

COMMUNEC

CATEG

COMPANY THEMES

EFFICACY PERCEPTIONS CAN ACT AS A BARRIER

HEALTH SYSTEM RESOURCE CONSTRAINTS

MYTHS, FEARS, AND OTHER BARRIERS TO PrEP UPTAKE AND ADHERENCE

OPPORTUNITIES FOR PrEP TO BE A GAMECHANGER

EFFICACY PERCEPTIONS CAN ACT AS A BARRIER

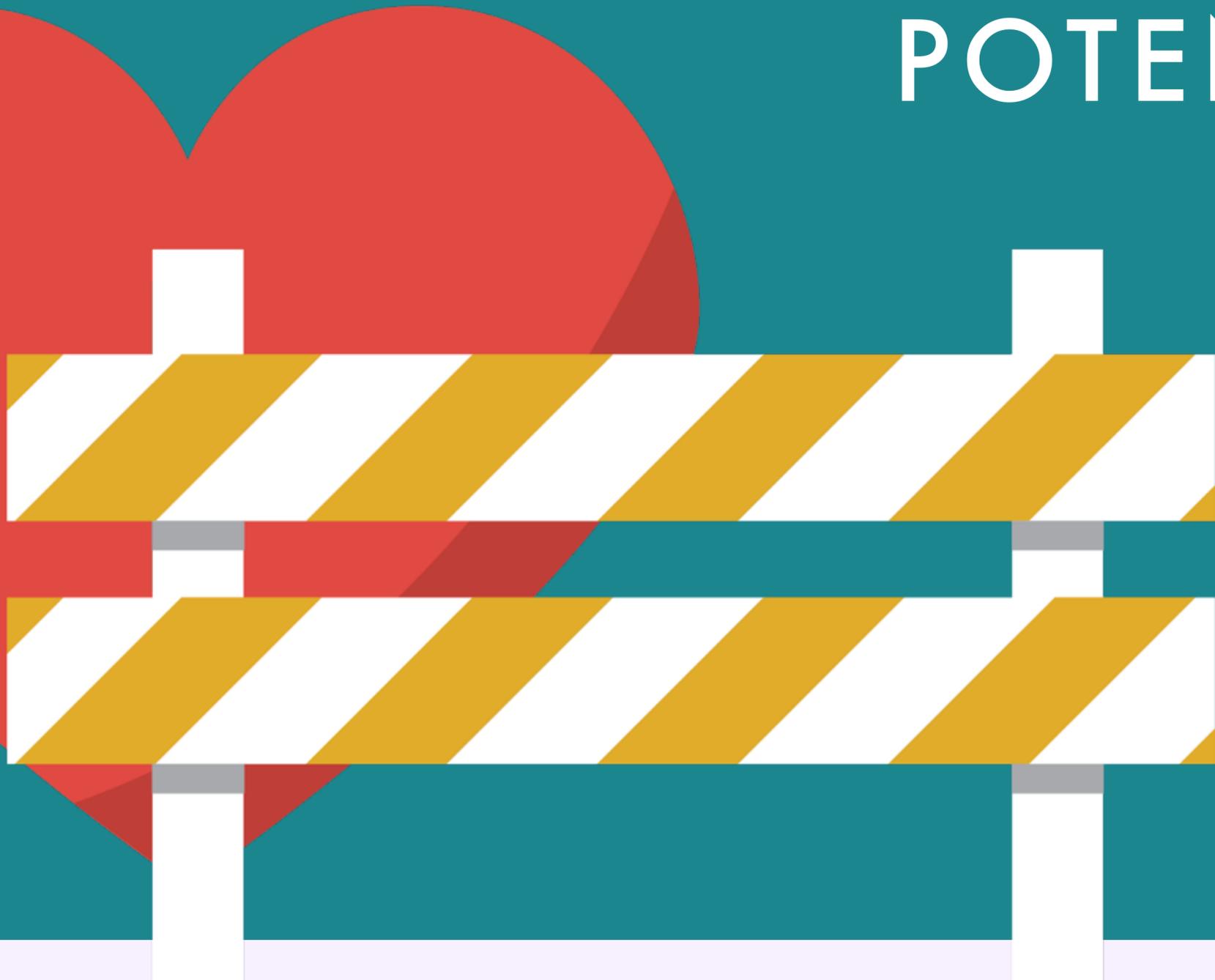


HCWs WHO ARE NOT CONVINCED OF THE DRUG'S EFFICACY

- HCWs' willingness to discuss PrEP options could be a function of a product's efficacy (Microbicide study: Harper et al./2012).*
- It's a possibility that HCWs who have either been involved in previous PrEP trials or who have limited-to-no knowledge of what PrEP is, could act as a barrier to TRUVADA being offered/recommended as a HIV prevention intervention.
- If HCWs are not sufficiently trained on when, where and how to offer Truvada, this could act as a barrier to uptake. This was seen with the implementation of Option B + in Western Kenya as well with oral PrEP in South Africa.

“What the doctors know about PrEP is low—could make a big impact as it took a few starts to get on it; I needed tenacity.”
—MSM, PrEP for MSM Meeting, South Africa

HEALTH SYSTEM CONSTRAINTS CAN ALSO ACT AS POTENTIAL BARRIERS



RESOURCE CONSTRAINTS MAY NEED TO BE OVERCOME

- **STAFF SHORTAGES:** Undermine the quality of the services and can have a negative impact on uptake and adherence
- **DRUG SHORTAGES:** Can result in inconsistent treatment and pose a barrier to adherence
- **LONG QUEUES:** Understaffing and the high demand of HIV-related services can increase the waiting time and result in significant barriers to accessing care
- **SPACE LIMITATIONS:** Limited space in clinics precludes privacy resulting in inadvertent HIV status disclosure
- **LACK OF CLIENT-FRIENDLY SERVICES:** Scolding of patients for lack of retention and adherence has been found to result in poor retention or defaulting
- **LACK OF INTEGRATION SERVICES:** Separate visits can create additional barriers for accessing care

“Getting the drugs is a major difficulty...The patients are just kept waiting endlessly and that discourages...you are just there and no one is attending to you or telling you anything.”

The background is a solid teal color. On the right side, there are several abstract, organic shapes in a lighter shade of teal, resembling a hand or a stylized figure. The text is centered on the left side of the page.

CONSUMER MYTHS, FEARS, AND OTHER BARRIERS TO PrEP UPTAKE AND ADHERENCE

PREP WILL DISRUPT ESTABLISHED SAFE SEX PRACTICES

TRUVADA WILL PROMOTE RECKLESS BEHAVIOR

“[Healthcare] providers and older generations [believe that it] allows people not to hold themselves accountable.”

–Stakeholder Interview, Connie Celum, Researcher

“I CAN STOP BOTHERING WITH CONDOMS.”

As we know, PrEP should be used in combination with the currently available set of interventions. However, the fear has arisen—especially among FSW—that the very existence of PrEP will discourage or disrupt established safe sex practices. It’s an alarming reality given the conspiracy theory that this could, in fact, be a way of spreading HIV among FSW in order to “control” their numbers.*

However, an examination of DHS data on men’s condom use in 10 African countries with the highest HIV prevalence finds that in most of these countries, significantly less than half report using a condom at last sex with any partner.

In others words, the behavior of not using a condom is more common than the behavior of using a condom.

One way to potentially overcome this fear is to consistently include the ‘combination prevention’ message when educating our audiences about Truvada.*

However, the combination prevention is a double-edged sword in that while it can calm fears related to safeguarding safe sex practices, it can also lead people to ask themselves whether PrEP is worth it if they still need to use a condom.

The solution may be to educate people on how rarely condoms are actually used.

OPTIONS Situational Analysis, May 2016

Women and ARV-based HIV prevention - challenges and opportunities, C Gerary and E Bukusi JAIS, 2014

Sex workers’ hopes and fears for HIV pre-exposure prophylaxis: recommendations from a UNAIDS consultation meeting, Nov 2013

PreP Perspectives: Findings from Key Informant and Mental Models Interviews. POWER, 2016

** Stakeholder Interview, Grace Kamau, KP Consortium*

THE STIGMA OF THE “BLUE PILL”

1. FEAR: BEING LABELED AS PROMISCUOUS OR A PROSTITUTE, RESULTING IN FURTHER SOCIAL EXCLUSION

- Women and girls have expressed concerns that taking an ARV-based prevention method would lead others to infer that they “were sick” as the “blue pills” are known to many as HIV treatment.
- Young girls have also expressed fear that there will be stigma as a result of being sexually active. In Uganda, a “good girl” is abstinent, which casts those who have sex as “bad girls.”
- Female sex workers feared further stigmatization and losing clients. They concealed the pills from others and hoped their appearance could be made ‘non-descript.’
- Integration of services could help mitigate this fear. [Gay et al./2010]

2. FEAR: SAME COLOR AS A DRUG USED TO SPIKE DRINKS

- FSW have also expressed concerns around the color of the pill being the same color as the “one used to spike drinks.”*

Women’s Experiences with Oral and Vaginal Pre-Exposure Prophylaxis: The VOICE-C Qualitative Study in Johannesburg, South Africa. PLoS ONE 2014
Young African Women Must Have Empowering and Receptive Social Environments for HIV Prevention. HIV 2011
The Promise and Peril of Pre-Exposure Prophylaxis (PrEP): Using Social Science to Inform PrEP Interventions among Female Sex Workers. African Journal of Reproductive Health. U.S. National Library of Medicine 2014
WhatWorksForWomen.org

* Stakeholder Interview, Grace Kamau, KP Consortium

BARRIERS TO UPTAKE

INDIVIDUAL PHYSICAL BARRIERS

- Fear of the side-effects: Including the interaction with drug & alcohol abuse (which can precede sex)
- Pill characteristics: Pill too large; (connected to: “Someone will eventually find out that I’m taking them. I can’t hide it like an injection.”)
- Not feeling sick
- Pill efficacy uncertainty
- Still having to use a condom when using PrEP

INDIVIDUAL EMOTIONAL BARRIERS

- Risk perception: low risk = seeing no use for the need for PrEP (‘present-bias’)
- Fear of HIV testing and learning one’s status (not only because of the emotional burden but because in terms of the HCWA Act, non-disclosure of positive status to a partner is a criminal offense)
- Threat of inter-partner violence
- Lack of support from their partners/family

SOCIAL BARRIERS

- Fear of an additional source of stigma: “The possession of PrEP could be used to identify and stigmatize me as [MSM/A sex worker/promiscuous] and as responsible for the spread of HIV.”
- Negative treatment from HCW (they therefore lie about risk factors that make patients eligible for PrEP)

ECONOMIC BARRIERS

- Cost could be a significant factor

Safety and Adherence to Intermittent PeEp for HIV-1 African Men Who Have sex with Men and Female Sex Workers, 2012, PLOS.org

Prep for MSM meeting in Africa, April 2016

AVAC Literature Review: Namey et al./2016, Cornelli et al./2015; Mack N et al.2014; Raphael et al./2012; Harper et al./2012; Van der Elst et al./2013; van der Straten et al./2014; Guest et al./2010; Syvertsen et al./2014; Mack et al./2014

Barriers and facilitators to pre-exposure prophylaxis (PrEP) eligibility screening and ongoing HIV testing among target population in Bondo and Rarieda, Kenya: Results of a consulting with community stakeholders (Mack et al, 2014)

PreP Perspectives: Findings from Key Informant and Mental Models Interviews. POWER, 2016

“How I Wish This Thing Was Initiated 100 Years Ago!” Willingness to Take Daily Oral Pre-Exposure Prophylaxis among Men Who Have Sex with Men in Kenya. Robinson Njoroge Karuga. 2016

BARRIERS TO ADHERENCE

INDIVIDUAL BARRIERS

- Illness or stress
- Forgetting. Keeping the pills visible could be a useful reminder, however in some cases women have to hide them to avoid partner conflict
- HIV testing every 3 months (2016 POWER research)
- ‘Present-bias’/’Optimism-bias’

RELATIONSHIP BARRIERS

- Inter-partner violence*
- Partner sabotage (Ex. Throwing the pills away)*

LIFESTYLE BARRIERS

- Change employment or school schedule
- Travel
- Migration
- Alcohol or drug use
- Socializing or holiday festivals

CHANGE IN LIFE PHASE (LEADING THE PERSON TO BELIEVE THEY’RE NOT AT RISK FOR HIV ANYMORE)

- Change in relationship status – to single/ steady**
- Pregnancy**



AVAC Literature Review: Namey et al./2016, Cornelli et al./2015, van de Straten./2014, Van der Elst et al./2013, Ware et al./2012,

* Intimate Partner Violence and Adherence to HIV Pre-exposure Prophylaxis (PrEP) in African Women in HIV Serodiscordant Relationships: A Prospective Cohort Study. Roberts ST, 2016

** When and why women might suspend PrEP use according to perceived seasons of risk: implications for PrEP-specific risk-reduction counselling. Namey E, 2016

PrEP ADHERENCE STRATEGIES

SOCIAL SUPPORT:

PrEP trials have found social support from partners, family, or other trial participants may improve adherence. And, in the FEM-PrEP trial, socializing with other participants was cited as an adherence motivator.

Social support for adolescent girls may be complicated by norms stigmatizing early sexual debut and sexual activity. The research on this should be explored further.

TECHNOLOGICAL INNOVATIONS:

Text messages sent to AGYW on a less-than-daily basis with content and timing that is tailored and requires a reply have been shown support adherence. Another option is using something like the [Bedsider app](#).

ADHERENCE COUNSELING:

Counselling in PrEP trials is often cited as improving adherence. However, the content and practices are not always articulated. In the CAPRISA 004 Vaginal Gel Trial in South Africa an Adherence Support Program (ASP) was tested and was found to have a significant impact on adherence. The counselling began midway through the trial and consisted of: (1) provision of non-judgmental, individualized adherence support; (2) separation of adherence assessment from adherence support counselling; (3) facilitation of normative support for adherence and accurate reporting of it. Tenofovir was detectable in **41%** of pre-ASP samples compared to **63%** of post-ASP samples.

Youth may also require additional and tailored adherence counselling. When supported to do so, women in a South African PrEP trial were able to adhere to daily dosing.

Cognitive behavioural therapy has been successful in with treatment in various areas for youth, but has yet to be tested for prevention.

CARRYING, CONCEALING, AND STORAGE:

Storage choices seem driven by the need to conceal or the need to recall. In one trial, women stored the pills in concealed places (e.g. drawers or their handbag) while others used places likely to be regularly seen (e.g. on top of appliances, furniture in bedroom). One study of MSM and FSW found various devices increased adherence such as a keychain pill caddy (concealing, ready at hand), MEMS caps on the pill containers, and reporting pill taking.

DOSING:

Which dosing regimen will improve adherence is not clear. Some women think an intermittent dosing schedule would lessen the burden of taking daily pill, while another study found daily dosage resulting in better coverage of sex acts than intermittent or coitally-dependent dosage. It is believed that daily dosage may become habit-forming and would be more forgiving of missed doses. Still other women in the VOICE Trial favoured a longer-acting option, lessening the probability of user-error. Choosing dosing times consistent with daily schedules or routines or using phone alarms were found to be helpful.

CONDITIONAL CASH TRANSFERS:

Microfinance programs or conditional cash transfers, by addressing economic disparities and immediate deprivations, have the potential to improve PrEP uptake and adherence and overcome the “present-bias” by “bringing rewards closer to the present.” Conditional cash transfers incentivizing reductions in risky behaviour (e.g. delay sexual debut, condom use, staying in school) have found some success among adolescent girls.



HCW BARRIERS AND LEVERS TO PRESCRIBING PrEP

While awareness of and knowledge of PrEP seems to be growing,
many barriers still exist in terms of prescribing PrEP.

“Healthcare workers are becoming more aware of PrEP. But only PrEP as a concept, not the nitty gritty details.”

–Stakeholder Interview, Caroline Ng’eno,
Regional Director, ICAP

The following information entails a summary of findings of healthcare providers in SSA specifically in relation to AGYW*

* *OPTIONS Knowledge, Attitudes and Practices of PrEP Providers Working With AGYW: A Review of completed, ongoing and planned studies. December 2016*

WHAT MAKES HCW'S FEEL UNCOMFORTABLE PRESCRIBING

KNOWLEDGE & EXPERIENCE CONCERNS:

- Lack of clear guidance and timely information regarding drug resistance, risk compensation and health effects (e.g. impact on bone density and off-label uses)
- Lack of knowledge (with regards to PrEP or certain populations such as PWID and youth)
- Inexperience with prescribing PrEP, including lack of peer norms, prescribing practices and screening/eligibility training (“Who is most at-risk?”)
- Lack of confidence around adherence (“The real world constraints of efficacy outside the supportive environment of clinical trials”)

PERSONAL BIASES:

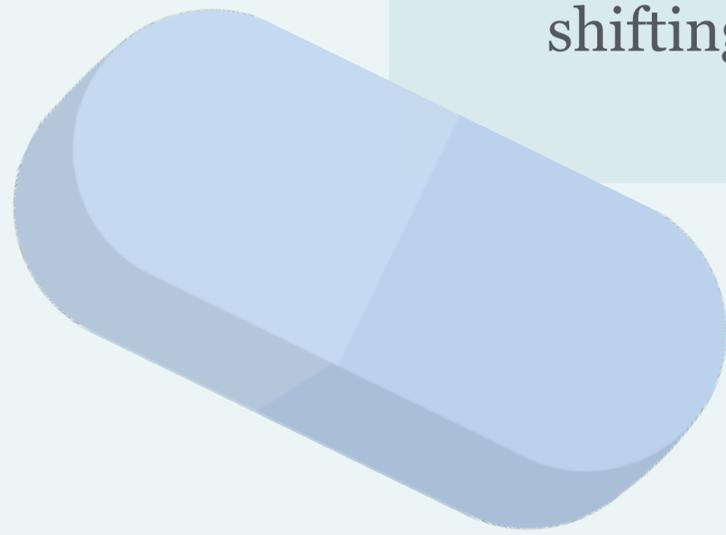
- Encouraging “bad behaviors;” beliefs that behavioral interventions would be more effective (“Just a party drug;” “A gay man’s prevention tool”)
- Discomfort discussing sexual activity with patients of different populations

INFRASTRUCTURAL CONCERNS:

- Unreliability of supply, extra space needed for storage, dispensing of PrEP and completion of lab tests, lack of space needed for confidentiality
- Inability to provide needed monitoring (“I can’t think up any other [preventive strategy] on the top of my head...that needs quite the amount of necessary monitoring”)

LEVERS TO PRESCRIBING PrEP

- Having experience with prescribing PEP or ARV's in the past
- Having formal country guidelines
- Training for lower-level staff to promote task shifting



INFORMATION NEEDED TO PRESCRIBE PrEP

- Efficacy
- Peer norms and prescribing practices
- Formalized guidelines, protocols and recommendations
- Training on care, counseling and administrative issues for PrEP and PrEP follow-up
- Competencies in terms of taking sexual histories and sensitivity to sexual minorities

OPPORTUNITY FOR PrEP TO BE A GAMECHANGER



PrEP OFFERS PROTECTION WHEN THERE AREN'T OTHER FORMS AT HAND

“I tell them ‘Security starts with you. PrEP starts with you. You are securing the future. You are securing your health.’”

—Brandon Kimani, PrEP Ambassador

- Serodiscordant couples (SDC) have cited PrEP as a way to circumvent the disadvantages of condoms and enjoy sex more, reduce fear of breakage, and protect their partner.
- In the VOICE trial, women in unequal power relationships, with limited ability to negotiate condoms, and suspecting their partner to be unfaithful, found PrEP a welcome alternative. Use can be concealed from one’s partner to avoid conflict.
- Female sex workers (FSW) may find PrEP to be a solution to the problem of negotiating condoms. Some FSW found PrEP to be a convenient and controllable alternative given the problems of negotiating condom use with their clients.
- Furthermore, FSW also saw PrEP as a way of making more money either by taking more clients or charging them more for sex without condoms.
- In a qualitative study in SA and Kenya, adolescent girls found PrEP appealing because they could avoid the stigma associated with collecting condoms from a clinic.
- PrEP may provide a solution to those practicing religions that forbid contraception.
- Finally, PrEP may offer that level of protection needed by FSW, girls and women when they are victims of sexual violence/abuse.

Ware et al. “What’s Love Got to Do With It? Explaining Adherence to Oral Antiretroviral Pre-Exposure Prophylaxis (PrEP) for HIV Serodiscordant Couples” (Partners PrEP Trial)

Van der Straten et al. “Women’s Experiences with Oral and Vaginal Pre-Exposure Prophylaxis: The VOICE-C Qualitative Study in Johannesburg, South Africa

Greene et al. “Acceptability and Adherence of a Candidate Microbicide Gel Among High-Risk Women in Africa and India”

Van der Elst et al. “High Acceptability of HIV Pre-Exposure Prophylaxis but Challenges in Adherence and Use: Qualitative Insights from a Phase I Trial of Intermittent and Daily PrEP in At-Risk Populations in Kenya”

Corneli et al. “Motivations for Reducing Other HIV Risk-Reduction Practices if Taking Pre-Exposure Prophylaxis: Findings from a Qualitative Study Among Women in Kenya and South Africa

PrEP IS A MEANS OF EMPOWERMENT

“PrEP offers FSW empowerment – they have the tool itself (in their hands), they have it when, where, and how they need it.”

–Stakeholder Interview, Grace Kamau, KP Consortium

“For the first time, I feel like I’m in control of my health.”

–AGYW, ICPC-Kenya (LVCT Health Prep Demo Project)*

“Message for young girls: love yourself and take care of yourself – because it cuts across, giving yourself the best options. From an empowerment and protection lens: eat right, sleep right, go to school, do what is right for yourself.”

–Stakeholder Interview, Elizabeth Bukusi, Researcher

HOWEVER, ‘EMPOWERMENT’ MAY NOT BE A MESSAGE THAT WORKS ACROSS ALL KEY POPULATIONS.

“Protect yourself” wouldn’t work because there is a lot of self-hate; lack of employment and money, lost families and friends, when they don’t have a lot to live for...especially for those MSM whose coming out experience has been very difficult, these may be the most difficult people to reach.”

–Stakeholder Interview, Brian Macharia, GALCK

* End-User Research Landscape Mapping, HIV PMM, AVAC, Published Jan 2017

PREP PROVIDES ADDITIONAL PROTECTION

Research has found that many couples felt safer when using PrEP. It can be seen as a backup to protect them either when their partner refuses to wear condoms or in cases of condom breakages.

I Knew I would be safer. Experiences of Kenyan HIV Serodiscordant Couples Soon After PrEP Initiation. Kenneth Ngure et al. AIDS Patient Care and STDs. 2016.

PrEP CAN
DEMONSTRATE
COMMITMENT AS
A COUPLE AND
THE SHARED
OWNERSHIP/
RESPONSIBILITY
OF THE
MANAGEMENT
OF HIV
INFECTION.

“Now I will continue with it til it is finished. I just wanted to motivate my wife so that she can (see) that she is not alone. While she takes medicine, I also take... she takes her and I take mine, we live the way we have been living.” (M-)

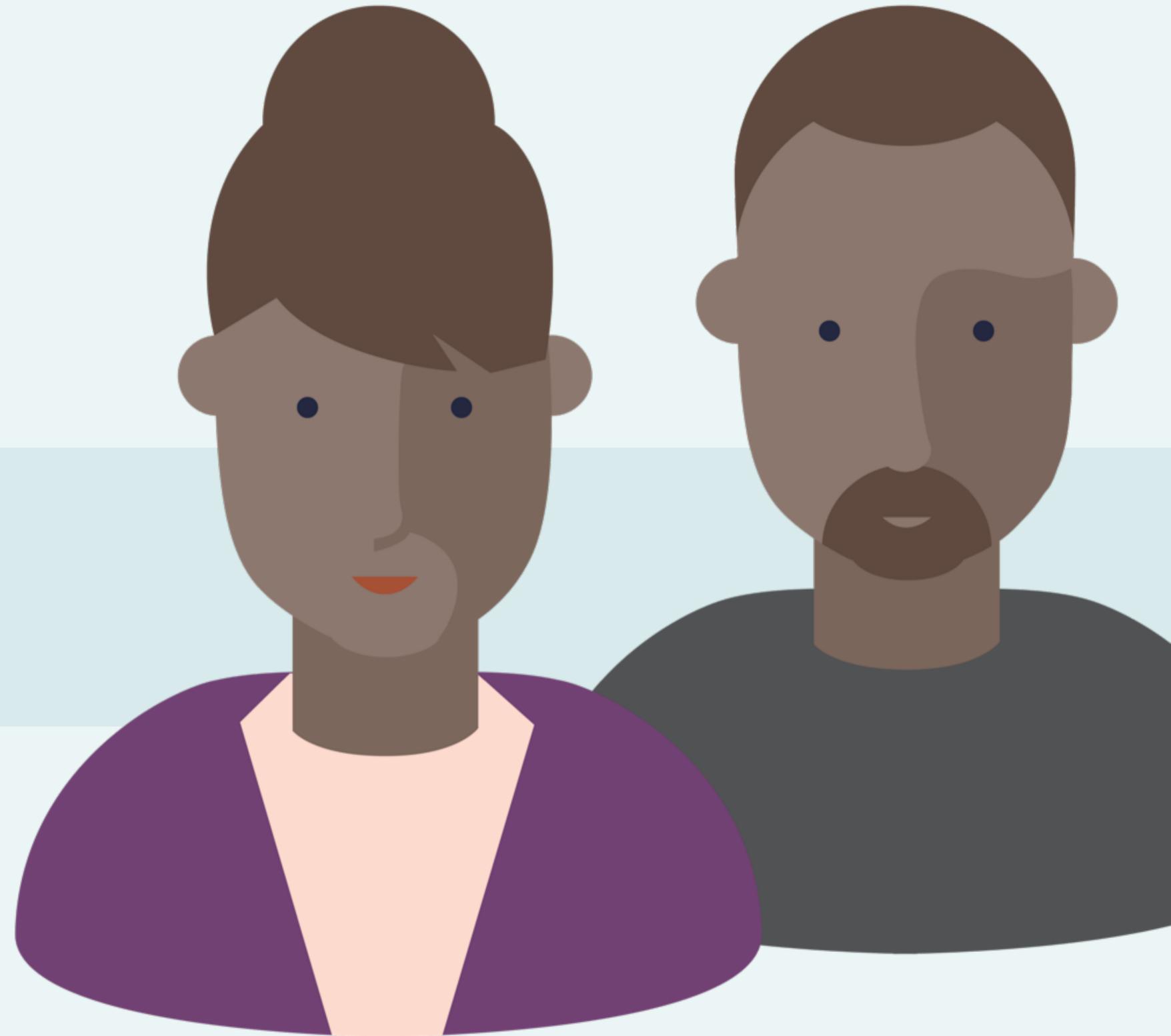
PREP CAN OFFER A WAY OF RESUMING A NORMAL LIFE*

“The medicine (PrEP) has been beneficial because since she knew her status and I knew my status, our lives have gone on as normal” (M-)

“Since we started taking (PrEP) we feel like we have a good future, earlier on we had seen death.” (F-)

PrEP CAN OFFER A WAY OF IMPROVING COUPLES' SEX LIVES

In another study, SDCs hoped PrEP would replace condoms and improve their sex life.



The importance of choice in the rollout of ARV-based prevention to user groups in Kenya and South Africa: a qualitative study" Mack et al.

PrEP IS A SYMBOL OF HOPE

“I’m also a mother, looking towards the future, a woman with financial ambitions. If (PrEP) means that I can finally see my son go to university or build my home in my village, then so be it. PrEP can feel like a small price to pay for that end goal.”

–Peninah Mwangi, BHSEP

In a Ugandan study, couples who were experiencing the Discordance Dilemma said that they saw **PrEP as a safeguard, a symbol of hope and opportunity, a means of preserving one partner’s health without ending the relationship.***

In another study, HIV-affected individuals and couples asserted that the provision of safer conception services **improved their partnership dynamics** by fostering a supportive and respectful environment for them to achieve their reproductive goals.

*Ex. Giving them the “courage to face the fear of the unknown ... and face the future without any fear.”**

“This is the time when understanding each other is difficult so if you get proper counseling then it will make your life healthy.”

BUT ONLY IF MEN ARE ENGAGED

A partner's preferences have a powerful influence on not only whether a woman uses a product, but can also impact how she perceives the product herself.

Partner disclosure has also been shown to improve acceptability and adherence for PrEP.

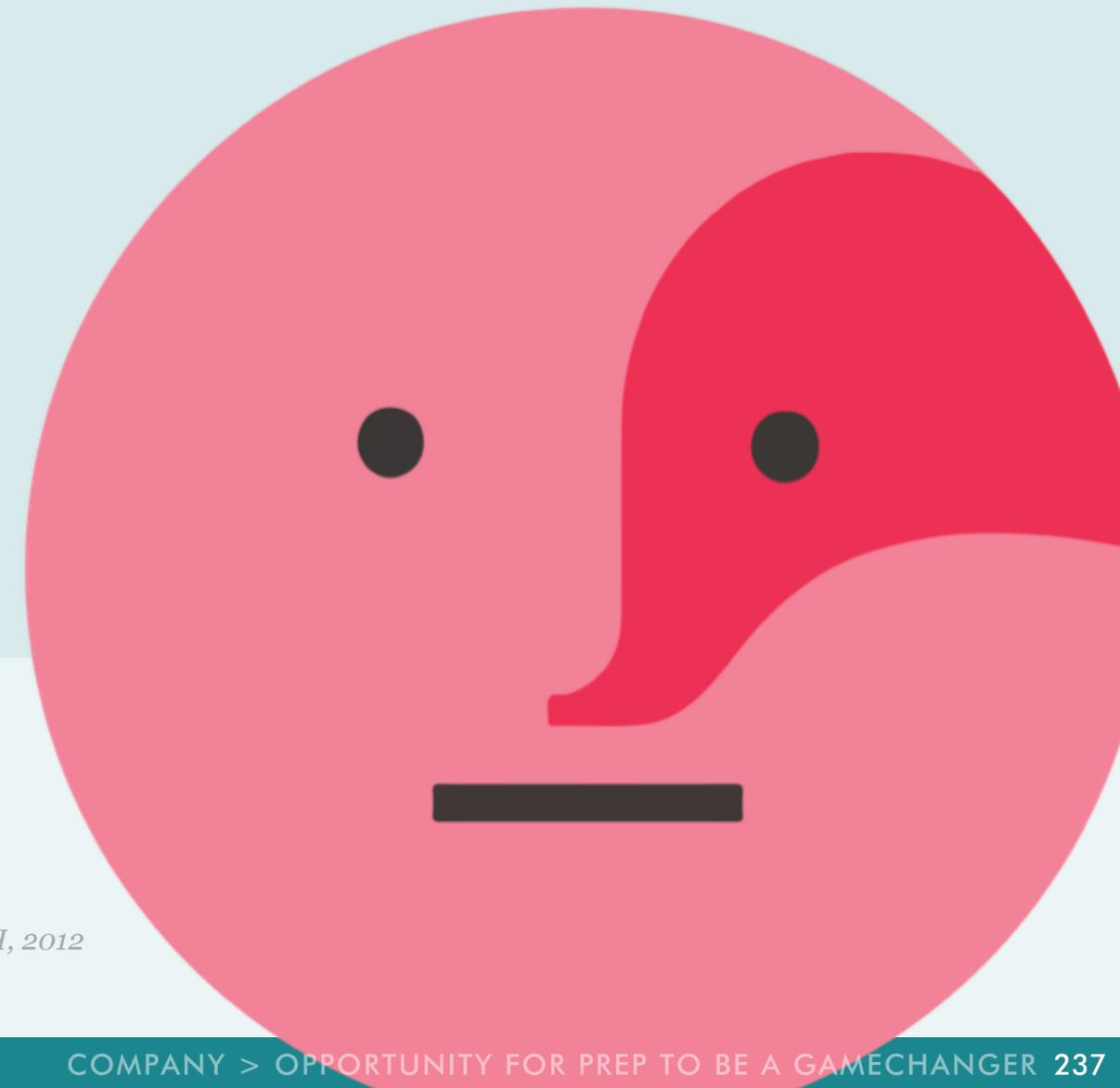
The study done in Uganda was particularly interesting because when the men were engaged, participants saw PrEP as **a way of improving their lives** and **they did whatever it took to make sure they or their partner adhered.**

Ex. Willingly traveled long distances, under difficult conditions, every month, to keep follow-up appointments and replenish pill supplies; They supplemented the travel stipend with their own funds, rather than renege on the opportunity offered by PrEP; They developed strategies for taking doses correctly.

Ex. Used reliable reminders – radio programs aired at dosing time, cell phone alarms – and selected dosing times compatible with work schedules.

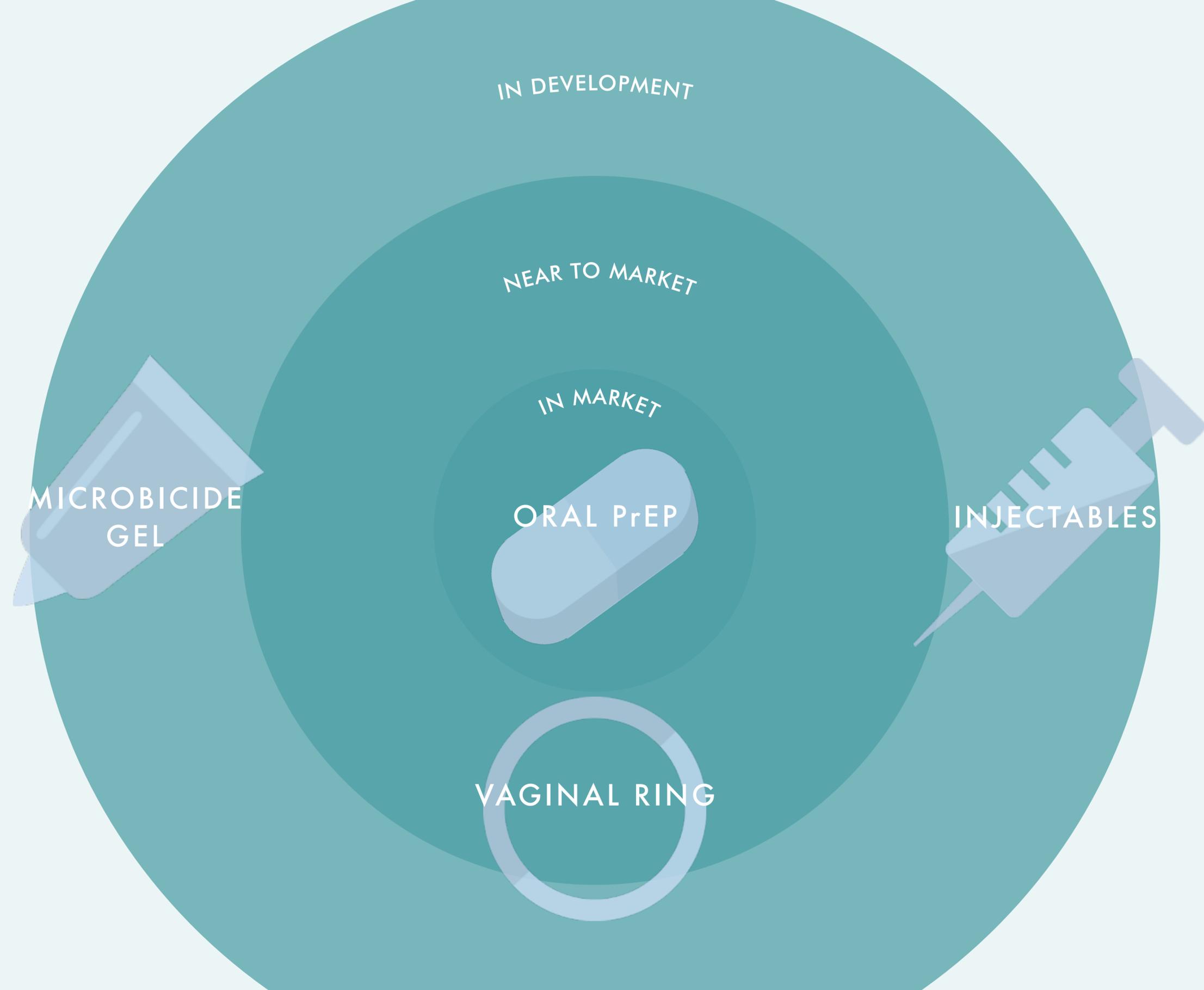
WE NEED TO TAKE MEN'S FEARS INTO ACCOUNT

- Fear about what the community might say about a man who has openly accepted PrEP:
Ex. He is “controlled/overpowered” by his wife, he is being “herded”
- Fear of being forced to reveal extramarital sexual activity
- Fear of being forced to have a vasectomy
- Fear of being laughed at if they accompany their wives to a health care center
- Fear of having to openly discuss sexual matters in front of their wives
- Fear of being perceived as giving their wives permission to be promiscuous



THE COMPETITIVE SET

NEW AND EXPANDING CATEGORY OF PRODUCTS



INJECTABLE PrEP

STILL IN
DEVELOPMENT

Allowing longer intervals between administration, this method may circumvent some of the adherence barriers found with other PrEP methods requiring pre-coital or daily administration.

In a qualitative study, most SDCs and FSWs said they would prefer Injectable PrEP because it is discrete, lasts longer, required little effort, and avoids common factors driving inconsistent use of condoms (e.g. forgetting, alcohol), though some feared needles and anticipated pain.*

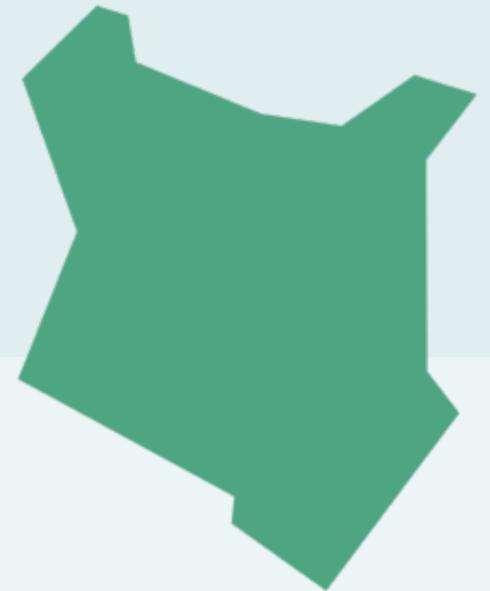
Adolescent girls also thought it would offer more privacy than condoms.

* It is worth noting that the women in this study may have been thinking about the family planning injectable as opposed to the PrEP injectable, which is larger and could be more painful.

TOP 3 CONTRACEPTIVES IN KENYA:

Use Contraceptive at all: **57.4%**

1. Injectable **28.1%**
2. Implant **10.8%**
3. Pill **8.6%**



*The importance of choice in the rollout of ARV-based prevention to user groups in Kenya and South Africa: a qualitative study, Journal of the International AIDS Society 2014
UN, 2015*

MICROBICIDE GEL

Microbicide gels have in their favour intermittent use; however, for some women, they are inconvenient and are subject to the same risks for inconsistent use as condoms: they need to be carried and available for sex acts which may not be planned; alcohol, drugs, and sexual arousal may limit pre-coital use; and perceived differences in lubrication (e.g. for regular partners) may reveal its use and spark conflict about infidelity.

- In the CAPRISA microbicide trial, young women felt the dosing requirements (requiring one gel application 12 hours before and 12 hours after) enabled them to use the microbicide discretely. But in other trials, women worried the timing requirements might make them more vulnerable to discovery.
- For vaginal gels, many male partners dislike the sensation of “wetness,” preferring drier or “dry sex.” Wetness, for some men, is also associated with illness, excessive sexual activity, infidelity, and prostitutes.

- Some FSW liked the lubrication as it reduced condom breakage and made sex less painful, enabling them to take more clients and make more money per day. In one study, those who had a pre-existing habit of lubricant use found lubricant gel easier to adopt.
- And, some FSW found the gel better than commercial lubricants because it was odourless and less likely to cause foul-smelling discharge.
- Sex workers also preferred to insert the gel in private, but those working on the street or in lodges found this difficult and in some cases cited this as reason for non-adherence.
- In a qualitative study, FSW thought post-coital use would be unlikely, due to exhaustion.
- Administration itself seems a lesser problem. In a trial with high-risk women, some had difficulty inserting the gel at the beginning, but confidence increased as the trial progressed.



STILL IN
DEVELOPMENT

The importance of choice in the rollout of ARV-based prevention to user groups in Kenya and South Africa: a qualitative study, Journal of the International AIDS Society 2014
Factors That Affect Acceptance of HIV Microbicides among Women. Collegian 2012
Rethinking HIV Prevention to Prepare for Oral PrEP Implementation for Young African Women. Journal of the International AIDS Society 2015
Acceptability and Adherence of a Candidate Microbicide Gel among High-risk Women in Africa and India. Culture, Health & Sexuality. U.S. National Library of Medicine
Hidden Harms: Women's Narratives of Intimate Partner Violence in a Microbicide Trial, South Africa. Social Science & Medicine 2014
Acceptability and Use of the Diaphragm and Replens® Lubricant Gel for HIV Prevention in Southern Africa." AIDS and Behavior 2009

VAGINAL RING

POTENTIALLY
NEAR TO
MARKET

Vaginal Rings (VR) may present a solution for some who find daily or pre-coital PrEP use burdensome. VRs have been designed in such a way as to release their chemical formulation (microbicide) slowly as they are worn continuously for a period of approximately 28 days. The ring is generally worn continuously, and is not to be removed for a duration of approximately 4 weeks.

- In the Dapivirine trial, only 2 (out of 16) users reported an accidental expulsion of the VR, while in the IPMO11 study 18% of users reported both deliberate (menstrual and disclosure purposes) and accidental removal (defecation, urination and during sex).*

- IPMO11 users found the ring easy to maintain and simple to use, which encouraged adherence.
- While mostly mild or just a minor inconvenience, there are some drawbacks to the VR use; in the Dapivirine trial, almost all participants using a VR reported at least one adverse event, which mostly included headaches, and some vaginal discomfort.

* Many women subsequently reported to have, in fact, deliberately removed the ring

MICROBICIDE GEL AND DIAPHRAGM

Women in the MIRA trial reported a diaphragm with microbicide gel easy to insert and remove (89%, 90%) and easy to retain inside during and post-sex (88%, 83%). Women who felt the gel consistency was “just right” or that it increased sexual pleasure were more likely to consistently use the diaphragm and gel.

Compared to condoms, the majority of women in one trial initially preferred diaphragms to condoms (57%), however, by the end of the trial 2 years later, more women found them equivalent, or favoured condoms.



STILL IN
DEVELOPMENT

ROLLOUT OF PREP

POLICY:

PrEP is incorporated into the Kenyan HIV Prevention Revolution Roadmap and is also identified as an evidence-based intervention in the most recent Kenya National Strategic Framework (KASF). PrEP is also included in the Guidelines on use of ARV drugs for treating and preventing HIV infections in Kenya—2016 edition.

NASCOP has also just published its PrEP guidelines to guide the start and use of PrEP.

RESEARCH:

Kenya's oral PrEP introduction activities include the LVCT Health demonstration project (sex workers and AGYW), MP3 Youth Project (mobile service delivery), Partners Demonstration Project (serodiscordant couples) and an expanded PrEP program targeting young women as part of PEPFAR's DREAMS initiative (AGYW and youth-friendly health services) around which The Population Council will be conducting qualitative research.

Bridge to Scale: The 3 goals of this effort include (1) strengthen supply and create demand of PrEP, (2) develop an acceptable and affordable approach to the launch and scale up of oral PrEP and (3) ensure political, donor, and community support.

ON THE GROUND:

The March 2017 (tentative) rollout will be based on county-level readiness and willingness. Counties have a large level of autonomy for the how and when this happens. In addition to developing a readiness assessment tool for health care facilities, NASCOP is also developing tools and resources to support them in the rollout.

KNOWLEDGE GAPS: COMPANY

- Need further information on Kenya's plans to introduce new PrEP products in the market.
- Need to understand current awareness levels of oral PrEP and preferences for different PrEP products, as well ways to incorporate men in conversation about PrEP uptake.
- Is 'empowerment' a message that works across audiences?
What different forms can this message take ('empowerment' is a broad term and concept that could cover a lot of different ideas), depending on the audience?

THANK YOU

SOURCES

CULTURE

“Kenyan Muslims Can Wear Hijab At Christian Schools - Court.” *BBC News*. 2017. Web. 10 Jan. 2017.

Lipka, Michael and Michael Lipka. "Africans Among The Most Morally Opposed To Contraception". *Pew Research Center*. 2017. Web. 10 Jan. 2017.

Adaji, Sunday E., et al. "The attitudes of Kenyan in-school adolescents toward sexual autonomy." *African Journal of Reproductive Health* 14.1 (2010).

Elisabeth Stoddard. "The Ubiquity of Religion in Kenya." *Berkley Center for Religion, Peace and World Affairs*. Web. 15 Jan. 2017.

“Global Commission on HIV and the Law.” *Global Commission on HIV and the Law*. Web. 16 Jan. 2017

Transcend Media Group. “Landscape Analysis: Desk Research for Kenya. January 2017.

“True Believers or Gospel Fakes?: Gospel Music in Kenya.” *This Is Africa Lifestyle.*, 27 June 2014. Web. 16 Jan. 2017.

Nekola, Adam. "Sub-Saharan Africa Religion Database." *Pew Research Center's Religion & Public Life Project*. 15 Apr. 2010. Web. 15 Jan. 2017

Kenya National Bureau of Statistics. Kenya: Demographic and Health Survey, 2014.

“People & Culture.” *Our Africa*. 2017. Web. 10 Jan. 2017.

Wike, Richard et al. "3. Kenyans Worried About Economy And Corruption, But Optimistic For The Future". *Pew Research Center's Global Attitudes Project*. N.p., 2017. Web. 10 Jan. 2017.

UNAIDS & THE AFRICAN UNION,. EMPOWER YOUNG WOMEN AND ADOLESCENT GIRLS. 2015. Web. 10 Jan. 2017.

Unemployment Rate - Country Comparison - TOP 100.” *Indexmundi.com*. N.p., 2017. Web. 10 Jan. 2017.

“Consumer Lifestyles In Kenya.” *Euromonitor.com*. N.p., 2017. Web. 10 Jan. 2017.

“Majorities In Kenya Optimistic About Their Economic Future.” *Pew Research Center's Global Attitudes Project*. N.p., 2017. Web. 10 Jan. 2017.

SOURCES

CONSUMER

SERODISCORDANT COUPLES

Ngure, Kenneth, et al. "A qualitative study of barriers to consistent condom use among HIV-1 serodiscordant couples in Kenya." *AIDS care* 24.4 (2012): 509-516.

Colombini, Manuela, Courtney James, and Charity Ndwiga. "The risks of partner violence following HIV status disclosure, and health service responses: narratives of women attending reproductive health services in Kenya." *Journal of the International AIDS Society* 19.1 (2016).

Ware, Norma C., et al. "What's love got to do with it? Explaining adherence to oral antiretroviral pre-exposure prophylaxis (PrEP) for HIV serodiscordant couples." *Journal of acquired immune deficiency syndromes (1999)* 59.5 (2012).

Ngure, Kenneth, et al. "My intention was a child but I was very afraid: fertility intentions and HIV risk perceptions among HIV-serodiscordant couples experiencing pregnancy in Kenya." *AIDS care* 26.10 (2014): 1283-1287.

Tsuma, Florence Chizi, and Allan Siangu Wekesa. "Challenges Facing HIV Discordant Couples in Kenya." *International Journal of Business and Social Science* 5.10 (2014).

Ngure, Kenneth, et al. "A qualitative study of barriers to consistent condom use among HIV-1 serodiscordant couples in Kenya." *AIDS care* 24.4 (2012): 509-516.

Stadler, Jonathan et al. "Hidden Harms: Women's Narratives of Intimate Partner Violence in a Microbicide Trial, South Africa." *Social Science & Medicine* 110 (2014): 49-55.

Carroll, Jennifer J., et al. "Gendered differences in the perceived risks and benefits of oral PrEP among HIV-serodiscordant couples in Kenya." *AIDS care* (2016): 1-7.

Rogers, Anna Joy, et al. "Couple interdependence impacts HIV-related health behaviours among pregnant couples in southwestern Kenya: a qualitative analysis." *Journal of the International AIDS Society* 19.1 (2016).

Mack, Natasha, et al. "Barriers and facilitators to pre-exposure prophylaxis (PrEP) eligibility screening and ongoing HIV testing among target populations in Bondo and Rarieda, Kenya: Results of a consultation with community stakeholders." *BMC health services research* 14.1 (2014): 1.

West, Nora, et al. "'I don't know if this is right... but this is what I'm offering': healthcare provider knowledge, practice, and attitudes towards safer conception for HIV-affected couples in the context of Southern African guidelines." *AIDS care* 28.3 (2016): 390-396.

OPTIONS. "Country Situation Analysis Interim Findings: Kenya" USAID & PEPFAR. April (2016).

SOURCES

CONSUMER

ADOLESCENT GIRLS & YOUNG WOMEN

“The Original Sin: A Letter from a Young Kenyan Girl to Herself by Aisha Ali Haji – The African Women's Development Fund (AWDF).” *The African Womens Development Fund AWDF*. Web. 15 Jan. 2017

Harper, Gary W., et al. “Ecological factors influencing HIV sexual risk and resilience among young people in rural Kenya: implications for prevention.” *Health education research* (2013): cyto81.

“Young People, HIV And AIDS | AVERT.” *AVERT*. 2017. Web. 10 Jan. 2017.

“Government of Kenya: National AIDS Control Council.” *KENYA NATIONAL AIDS STRATEGIC PLAN: 2009-2013*. Nairobi. 2009.

“Consumer Lifestyles in Kenya.” *Euromonitor*. 2013.

Redman, K. “Education for All Global Monitoring Report Fact Sheet October 2012: Education in Kenya.” *UNESCO*. Web 17 Jan 2017.

Hatcher, Abigail M., et al. “Social context and drivers of intimate partner violence in rural Kenya: implications for the health of pregnant women.” *Culture, health & sexuality* 15.4 (2013): 404-419.

“Get On The Fast-Track — The Life-Cycle Approach To HIV | UNAIDS.” *Unaid.org*. N.p., 2017. Web. 10 Jan. 2017.

Godia, Pamela M., et al. “Young people’s perception of sexual and reproductive health services in Kenya.” *BMC health services research* 14.1 (2014): 1.

STEP UP,. Status Report On The Sexual And Reproductive Health Of Adolescents Living In Urban Slums In Kenya. UKAID & APHRC, 2013. Web. 10 Jan. 2017.

“CITY GIRL: Yes She Has A ‘Sponsor’, So What?.” *Daily Nation*. N.p., 2017. Web. 10 Jan. 2017.

“Who Do You Love? Finding Treasure At The Last Day Of R4P.” *AVAC*. N.p., 2017. Web. 10 Jan. 2017.

Adaji, Sunday E., et al. “The attitudes of Kenyan in-school adolescents toward sexual autonomy.” *African Journal of Reproductive Health* 14.1 (2010).

Government of Kenya: Ministry of Medical Services and Ministry of Public Health and Sanitation: *Kenya Service Provision Assessment Survey 2010*. Kenya. 2011.

OPTIONS Knowledge, Attitudes and Practices of PrEP Providers Working With AGYW: A Review of completed, ongoing and planned studies. December 2016

SOURCES

CONSUMER

MEN WHO HAVE SEX WITH MEN

“List of issues to be taken up in connection with the consideration of the third periodic report of Kenya”, United Nations Human Rights Committee, 103rd session, Geneva, 22 November 2011, CCPR/C/KEN/3, paragraph 26, page 5

The Global Forum on MSM & HIV (MSMGF),. Access To HIV Prevention And Treatment For Men Who Have Sex With Men. 2012. Print.

Kenya Human Rights Commission,. *The Outlawed Among Us*. Nairobi: The Kenya Human Rights Commission, 2011. Print.

“What Is It Like Being Gay In Kenya?.” *Staying Alive Foundation*. MTV. 2017. Web. 10 Jan. 2017.

King, Rachel, et al. “Men at risk; a qualitative study on HIV risk, gender identity and violence among men who have sex with men who report high risk behavior in Kampala, Uganda.” *PloS one* 8.12 (2013): e82937.

NDUNGU, JOHN KINGORI. CAPACITY OF HEALTH SYSTEMS TO RESPOND TO HEALTH CONCERNS OF MEN WHO HAVE SEX WITH MEN IN NAIROBI. Diss. MOI UNIVERSITY, 2013.

UNAIDS. “Kenya AIDS Response Progress Report 2014 Progress towards Zero.” March 2014.

Nascopor. “National Key Populations Communication Strategy, 2014 – 2017 .” NASCOP. Web. 24 Jan. 2017.

Okal, Jerry, et al. “Social context, sexual risk perceptions and stigma: HIV vulnerability among male sex workers in Mombasa, Kenya.” *Culture, health & sexuality* 11.8 (2009): 811-826.

Okall, Dancun O., et al. “Men who have sex with men in Kisumu, Kenya: comfort in accessing health services and willingness to participate in HIV prevention studies.” *Journal of homosexuality* 61.12 (2014): 1712-1726.

Van der Elst, Elise M., et al. “Experiences of Kenyan healthcare workers providing services to men who have sex with men: qualitative findings from a sensitivity training programme.” *J Int AIDS Soc* 16.4 (2013).

SOURCES

CONSUMER

FEMALE SEX WORKERS

“About Us” Keeping Alive Societies Hope. Web. 14 Jan. 17.

Baral, Stefan, et al. “Burden of HIV among female sex workers in low-income and middle-income countries: a systematic review and meta-analysis.” *The Lancet infectious diseases* 12.7 (2012): 538-549.

African Sex Worker Alliance. “I expect to be abused and I have fear: Sex workers’ experiences of human rights violations and barriers to accessing healthcare in four African countries.” Final Report. April 2011.

Lafort, Yves. “Where Do Female Sex Workers Seek HIV and Reproductive Health Care and What Motivates These Choices? A Survey in 4 Cities in India, Kenya, Mozambique and South Africa.” *Plos One* 11.8 (2016)

Republic of Kenya. Kenya: HIV Prevention Response and Modes of Transmission Analysis. Final Report. March 2009.

Mack, Natasha, et al. “Barriers and facilitators to pre-exposure prophylaxis (PrEP) eligibility screening and ongoing HIV testing among target populations in Bondo and Rarieda, Kenya: Results of a consultation with community stakeholders.” *BMC health services research* 14.1 (2014): 1.

Camlin, Carol S., et al. “‘She mixes her business:’ HIV transmission and acquisition risks among female migrants in western Kenya.” *Social science & medicine* 102 (2014): 146-156.

Micheni, Murugi, et al. “Risk of sexual, physical and verbal assaults on men who have sex with men and female sex workers in coastal Kenya.” *AIDS (London, England)* 29.0 3 (2015): S231.

Nascopor. “National Key Populations Communication Strategy, 2014 – 2017 .” NASCOP. Web. 24 Jan. 2017.

International Organization for Migration. Integrated Biological and Behavioural Surveillance Survey Among Migrant Female Sex Workers in Nairobi, Kenya 2010. 2011.

Corneli, Amy, et al. “Contraceptive service delivery in Kenya: A qualitative study to identify barriers and preferences among female sex workers and health care providers.” *Contraception* 94.1 (2016): 34-39.

SOURCES

CONSUMER

PEOPLE WHO INJECT DRUGS

Njagi, David. "Kenya: Hope for People Who Use Drugs." AllAfrica.com. N.p., 20 Apr. 2016. Web. 11 Jan. 2017.

Stone, Katie. The Global State of Harm Reduction 2014. *Harm Reduction International*, 2014

"The Gap Report 2014: People Who Inject Drugs" *UNAIDS*, 2014.

Reid, Savanna R. "Injection Drug Use, Unsafe Medical Injections, and HIV in Africa: A Systematic Review." *Harm Reduction Journal* 6.1 (2009): 24.

Reuters. "Surging Heroin Use Threatens Kenya's HIV/AIDS Gains." *Fox News*. FOX News Network, 19 July 2016. Web. 11 Jan. 2017

Guise, Andy, et al. "A Qualitative Analysis of Transitions to Heroin Injection in Kenya: Implications for HIV Prevention and Harm Reduction." *Harm Reduction Journal* 12.1 (2015).

Tun, Waimar et al. "HIV and STI Prevalence and Injection Behaviors Among People Who Inject Drugs in Nairobi: Results from a 2011 Bio-behavioral Study Using Respondent-Driven Sampling." *AIDS and Behavior* 19.S1 (2014): 24-35.

Kurth, Ann E. et al. "HIV Prevalence, Estimated Incidence, and Risk Behaviors Among People Who Inject Drugs in Kenya." *JAIDS Journal of Acquired Immune Deficiency Syndromes* 70.4 (2015): 420-27

Hyde, Lily. "Achievements and Challenges in introducing a harm reduction program in Kenya: A case study." *Community Action on Harm Reduction*. 2016.

Green, Amy. "How Africa's Addicts Are Being Helped to Stay HIV-free." *Bhekisisa*. Web. 11 Jan. 2017.

Guise, Andy, et al. "Access to HIV Treatment and Care for People Who Inject Drugs in Kenya: A Short Report." *AIDS Care* 28.12 (2016): 1595-599.

"AIDS 2014: Peer Programs Engage Injection Drug Users in Kenya and Tanzania." *Science Speaks: Global ID News*. Web. 11 Jan. 2017

Kageha, Emmy. "Drugs Laws and Human Rights in Kenya: Disharmony in the Law and Training Recommendations to Law Enforcement." *HIV Gaps*. 2015

Mutuki, Andrew "End line evaluation report for the community action on harm reduction project in Kenya. *Community Action on Harm Reduction*, 2014.

Nascopor. "National Key Populations Communication Strategy, 2014 – 2017 ." NASCOP. Web. 24 Jan. 2017.

Graham Shaw. "Independent Evaluation: Community Action on Harm Reduction" *Community Action on Harm Reduction*, 2014.

SOURCES

CONSUMER

HEALTH CARE WORKERS

Taegtmeyer M, Suckling RM, Nguku PM, Meredith C, Kibaru J, Chakaya JM, Muchela H, Gilks CF. Working with risk: Occupational safety issues among healthcare workers in Kenya. *AIDS Care*. 20.3 (2008):304-10.

Mbaisi, E. M., Wanzala, P., & Omolo, J. (2013). "Prevalence and Factors Associated with Percutaneous Injuries and Splash Exposures among Health-care Workers in a Provincial Hospital, Kenya, 2010." *Pan African Medical Journal* 14 (2013).

Bott, S., Neuman, M., Hellingrader, S., Desclaux, A., El Asmar, K., & Obermeyer, C. M. "Rewards and Challenges of Providing HIV Testing and Counselling Services: Health Worker Perspectives from Burkina Faso, Kenya and Uganda." *Health Policy and Planning* 30.8 (2014): 964-75

Goetz, K., Marx, M., Marx, I., Brodowski, M., Nafula, M., Prytherch, H., ... & Szecsenyi, J. "Working Atmosphere and Job Satisfaction of Health Care Staff in Kenya: An Exploratory Study." *BioMed Research International* 2015 (2015): 1-7.

Helova, Anna et al. "Health Facility Challenges to the Provision of Option B in Western Kenya: A Qualitative Study." *Health Policy and Planning* (2016)

Jenkins, R., Othieno, C., Okeyo, S., Aruwa, J., Wallcraft, J., & Jenkins, B."Exploring the Perspectives and Experiences of Health Workers at Primary Health Facilities in Kenya following Training." *International Journal of Mental Health Systems* 7.1 (2013): 6.

Kawakatsu, Y., Sugishita, T., Kioko, J., Ishimura, A., & Honda, S. "Factors Influencing the Performance of Community Health Workers in Kisumu West, Kenya." *Primary Health Care Research & Development* 13.04 (2012): 294-300.

Kawakatsu, Y., Sugishita, T., Tsutsui, J., Oruenjo, K., Wakhule, S., Kibosia, K., ... & Honda, S. "Individual and Contextual Factors Associated with Community Health Workers' Performance in Nyanza Province, Kenya: A Multilevel Analysis." *BMC Health Services Research* 15.1 (2015)

Masika, Moses. "Why Kenyan Health Workers Are on Strike and What Can Be Done about It." *MG Africa*. N.p., 14 Dec. 2016. Web. 11 Jan. 2017.

Mbindyo, P. M., Blaauw, D., Gilson, L., & English, M."Developing a Tool to Measure Health Worker Motivation in District Hospitals in Kenya." *Human Resources for Health* 7.1 (2009): 1.

Mbindyo, P., Gilson, L., Blaauw, D., & English, M. "Contextual Influences on Health Worker Motivation in District Hospitals in Kenya." *Implementation Science* 4.1 (2009): 1.

Mbuva, A. Woman dies in Machakos. *The Starr*, 2016.

Ojakaa, D., Olango, S., & Jarvis, J."Factors Affecting Motivation and Retention of Primary Health Care Workers in Three Disparate Regions in Kenya." *Human Resources for Health* 12.1 (2014): 1.

Okal, J., Luchters, S., Geibel, S., Chersich, M. F., Lango, D., & Temmerman, M."Social Context, Sexual Risk Perceptions and Stigma: HIV Vulnerability among Male Sex Workers in Mombasa, Kenya." *Culture, Health & Sexuality* 11.8 (2009): 811-26.

Opollo, J. G., & Gray, J. "Stigma in HIV-infected Health Care Workers in Kenya: A Mixed-method Approach." *Journal of the Association of Nurses in AIDS Care* 26.5 (2015): 639-51.

Otieno, J. (2016). Nairobi nurses go four months without pay. *The Star*, Kenya. Retrived From: http://www.the-star.co.ke/news/2016/02/17/nairobi-nurses-go-four-months-without-pay_c1295241

Prince, R. J., & Otieno, P. (2014). "In the Shadowlands of Global Health: Observations from Health Workers in Kenya." *Global Public Health* 9.8 (2014): 927-45.

"Kenyan Health Care Workers Strike." *PSI*. 11 Jan. 2017

Smith, J., Odera, D. N., Chege, D., Muigai, E. N., Patnaik, P., Michaels-Strasser, S., ... & Dohrn, J. (2016)."Identifying the Gaps: An Assessment of Nurses' Training, Competency, and Practice in HIV Care and Treatment in Kenya." *Journal of the Association of Nurses in AIDS Care* 27.3 (2016): 322-30..

Takasugi, T., and A. C. K. Lee. "Why do community health workers volunteer? A qualitative study in Kenya." *Public Health* 126.10 (2012): 839-845.

Turan, J. M., Bukusi, E. A., Cohen, C. R., Sande, J., & Miller, S. "Effects of HIV/AIDS on maternity care providers in Kenya." *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 37.5 (2008): 588-595.

UN. "The impact of AIDS. Department of Economic and Social Affairs: Population Division." 2004

USAID. "Caregivers come together: HIV-positive health workers form new network in Kenya. Healthy Policy Initiative," 2009. Retrieved from: http://www.healthpolicyinitiative.com/Publications/Documents/874_1_Health_Workers_Network_FINAL_acc.pdf

k_FINAL_acc.pdf

Masika, Moses. "Why Kenyan Health Workers Are on Strike and What Can Be Done about It." *MG Africa*. N.p., 14 Dec. 2016. Web. 11 Jan. 2017.

SOURCES

CATEGORY

Kenya National Bureau of Statistics. "Kenya Demographic and Health Survey 2014" *DHS Program*, 2015.

UNAIDS, "The Gap Report 2014" *UNAIDS*, 2014.

Ministry of Health, "Kenya HIV Prevention Roadmap: Countdown to 2030" *GBV HIV Online*, 2014.

Ministry of Health, "Kenya AIDS Response Progress Report 2014: Progress Toward Zero" *UNAIDS*, 2014.

Kenya National AIDS Control Council, "Kenya: HIV Prevention Response and Modes of Transportation Analysis Final Report 2009." World Bank, 2009.

"Kenya 2008-09: Results from the Demographic and Health Survey." *Studies in Family Planning* 42.2 (2011): 131-36. Web.

"HIV and AIDS in Kenya." *AVERT*. Web. 11 Jan. 2017.

Integrating Female Condoms into HIV Prevention Programs "A case study of barriers, facilitators, and future opportunities in Kenya" *PATH* 2014

Bulimo, Amakoye S. Protective Magic: Luyia of Kenya, A Cultural Profile.

Palitza, Kristen. "Traditional leaders wield the power, and they are almost all men: The Importance of Involving Traditional Leaders in Gender Transformation" *K4Health*.

Bott, S., Neuman, M., Helleringer, S., Desclaux, A., El Asmar, K., & Obermeyer, C. M. "Rewards and Challenges of Providing HIV Testing and Counselling Services: Health Worker Perspectives from Burkina Faso, Kenya and Uganda." *Health Policy and Planning* 30.8 (2014): 964-75.

Broccoli, Morgan C., et al. "Perceptions of Emergency Care in Kenyan Communities Lacking Access to Formalised Emergency Medical Systems: A Qualitative Study" *BMJ Open* 5.11 (2015).

Prince, R. J., & Otieno, P. (2014). In the shadowlands of global health: Observations from health workers in Kenya. *Global public health*, 9(8), 927-945.

"Finding and Forging Trust in Health System Strengthening." *Duke Global Health Institute*. Web. 10 Jan. 2017

Republic of Kenya, Ministry of Health. "Health Sector: Human Resources Strategy 2014-2018" *Ministry of Health, Kenya*, 2014.

"People and Corruption: Africa Survey 2015 - Global Corruption Barometer" *Transparency International*, 2015.

Lubano, Kizito. "The Disease of Corruption Hits Kenya's Health Sector Hardest." *The Standard*. 27 Dec. 2016. Web. 13 Jan. 2017

MTV. "New Research Reveals MTV, UNICEF and PEPFAR's Ignite Campaign Has Altered Young People's Thinking About HIV/AIDS Attitudes and Behaviours." *PR Newswire*. Web. 12 Jan. 2017.

Levy, Julie. "MTV Shuga - A Multi-platform Communication Initiative Achieving HIV Behaviour Change for Adolescents in Africa." *The Communication Initiative Network*. Web. 12 Jan. 2017.

Undie, Chi-Chi et al. "Expanding access to comprehensive reproductive health and HIV information and services for married adolescent girls in Nyanza Province" *Popcouncil*, 2012.

"Voluntary Medical Male Circumcision for HIV Prevention." *AVERT*. N.p., n.d. Web. 10 Jan. 2017.

Kenya Ministry of Health "End-Term Review of Kenya's Voluntary Medical Male Circumcision Programme (2008-2013)." *MaleCircumcision.Org*, 2014.

"MHealth in Practice : Mobile Technology for Health Promotion in the Developing World." (2013): n. pag. FHI360. Web.

Bunyi, Mbogo. "Kenya: Evaluating the Impact of Mobiles for Reproductive Health" *SHOPS Project*, 2014.

Odeny, Thomas A., et al. "Texting Improves Testing: A Randomized Trial of Two-way SMS to Increase Postpartum Prevention of Mother-to-child Transmission Retention and Infant HIV Testing." *AIDS* 28.15 (2014): 2307-312. Web

"TB and HIV/AIDS Communications Campaign." *Danya International - TB and HIV/AIDS Communications Campaign*. N.p., n.d. Web. 10 Jan. 2017.

"Multimedia Communication Campaign on TB and HIV." *The Communication Initiative Network*. N.p., n.d. Web. 10 Jan. 2017.

"Support for CDC Kenya's Development and Implementation of a TB/HIV Communication Campaign." *Danya International*.

"Global ALL IN Campaign Fights Rising HIV Infections and Deaths among Adolescents." WHO. N.p., n.d. Web. 10 Jan. 2017.

"ALL IN to #EndAdolescentAIDS." ALL IN to #EndAdolescentAIDS. N.p., n.d. Web. 10 Jan. 2017.

Uhuru Kenyatta. "SPEECH BY HIS EXCELLENCY HON. UHURU KENYATTA, C.G.H., PRESIDENT AND COMMANDER IN CHIEF OF THE DEFENCE FORCES OF THE REPUBLIC OF KENYA AT THE OFFICIAL LAUNCH OF KENYA'S FAST-TRACK PLAN TO END ADOLESCENT AIDS AND THE HIV SITUATION ROOM AT KICC, NAIROBI ON 17TH SEPTEMBER, 2015." *President.Go.Ke*. N.p., n.d. Web. 10 Jan. 2017.

SOURCES

CONNECTIONS

“Population and Health Dynamics in Nairobi’s Informal Settlements: Report of the Nairobi Cross-sectional Slums Survey (NCSS).” *APHRC* 2012.

"Young Africa Live — Social Tech Guide." Social Tech Guide. N.p., n.d. Web. 10 Jan. 2017.

Communications Authority of Kenya. “Quarterly Sector Statistics Report: First Quarter of the Financial Year 2014/2015. 2014.

"Kenyan Company Makes Business Sense of Whatsapp, Eyes Global Market." Kenyan Company Makes Business Sense of Whatsapp, Eyes Global Market. N.p., n.d. Web. 10 Jan. 2017.

Digital Rand. “State of Social Media in Kenya” Report A002

Kerrigan, Deanna. Peer Education and HIV/AIDS: Concepts, Uses and Challenges. Geneva, Switzerland: *UNAIDS*, 1999. *UNAIDS*. Web.

"Aid Groups Grapple with Stigmatization in HIV Prophylaxis Roll-out." Devex. N.p., 18 Nov. 2016. Web. 10 Jan. 2017.

Nascopor. "Key Population." NASCOP. Web. 13 Jan. 2017.

"Genitalverstümmelung Und Beschneidung Von Frauen Erfolgreich Beenden." Fulda-Mosocho-Projekt. Web. 14 Jan. 2017

"Tasaru Ntomonok Initiative." Alliance Globale Contre Les Mutilations Genitales Feminines.

Oloo, Habil, Monica Wanjiru, and Katy Newell-Jones. Female Genital Mutilation Practices in Kenya: The Role of Alternative Rites of Passage: A Case Study of Kisii and Kuria Districts. London: Feed the Minds, 2011. Population Council.

"Maendeleo Ya Wanawake Organization." Maendeleo Ya Wanawake. Web. 14 Jan. 2017.

"Impact-RDO | Evidence Based Behavioral Interventions." Impact-RDO | Evidence Based Behavioral Interventions. Web. 15 Jan. 2017.

Transcend Media Group. “Landscape Analysis: Desk Research for Kenya. January 2017.

"What Is It like Being Gay in Kenya?" Staying Alive Foundation. Web. 10 Jan. 2017.

“End-User Research Landscape Mapping & Findings Jan 2017” *HIV Prevention Market Manager*. 14 Jan 2017.

Dellar, Rachael C., Sarah Dlamini, and Quarraisha Abdool Karim. "Adolescent Girls and Young Women: Key Populations for HIV Epidemic Control." *Journal of the International AIDS Society* 18.2(Suppl 1) (2015).

"Young People's Perception of Sexual and Reproductive Health Services in Kenya." *BMC Health Services Research*. Web. 10 Jan. 2017.

Withers, Mellissa et al. "Men's Perspectives on Their Role in Family Planning in Nyanza Province, Kenya." *Studies in Family Planning* 46.2 (2015): 201-15.

"Sex Workers and HIV/AIDS." *AVERT*. N.p., n.d. Web. 10 Jan. 2017.

Corneli, Amy. et al. "Contraceptive Service Delivery in Kenya: A Qualitative Study to Identify Barriers and Preferences among Female Sex Workers and Health Care Providers." *Contraception* 94.1 (2016): 34-39. Web.

SOURCES COMPANY

Helova, Anna et al. "Health Facility Challenges to the Provision of Option B in Western Kenya: A Qualitative Study." *Health Policy and Planning* (2016)

OPTIONS Situational Analysis, May 2016

Geary, Cynthia W., and Elizabeth A. Bukusi. "Women and ARV-based HIV Prevention – Challenges and Opportunities." *Journal of the International AIDS Society* 17.3(Suppl 2) (2014).

Sex workers' hopes and fears for HIV pre-exposure prophylaxis: recommendations from a UNAIDS consultation meeting, Nov 2013

PreP Perspectives: Findings from Key Informant and Mental Models Interviews. POWER, 2016

Straten, Ariane Van Der. "Women's Experiences with Oral and Vaginal Pre-Exposure Prophylaxis: The VOICE-C Qualitative Study in Johannesburg, South Africa." *PLoS ONE* 9.2 (2014).

Conn, Cath. "Young African Women Must Have Empowering and Receptive Social Environments for HIV Prevention." *HIV* (2011): 1-8.

Syvrtsen, Jennifer L. et al. "The Promise and Peril of Pre-Exposure Prophylaxis (PrEP): Using Social Science to Inform PrEP Interventions among Female Sex Workers." *African Journal of Reproductive Health. U.S. National Library of Medicine*, Sept. 2014. Web. 10 Jan. 2017.

Gay, et al. "What Works." What Works For Women and Girls: Evidence for HIV/AIDS Interventions. 2010. Web. 10 Jan. 2017.

Safety and Adherence to Intermittent PeEp for HIV-1 African Men Who Have sex with Men and Female Sex Workers, 2012, PLOS.org

Prep for MSM meeting in Africa, April 2016

Karuga, Robinson Njoroge et al. "How I Wish This Thing Was Initiated 100 Years Ago! Willingness to Take Daily Oral Pre-Exposure Prophylaxis among Men Who Have Sex with Men in Kenya." *Plos One* 11.4 (2016).

Mack, Natasha et al. "The Importance of Choice in the Rollout of ARV-based Prevention to User Groups in Kenya and South Africa: A Qualitative Study." *Journal of the International AIDS Society* 17.3(Suppl 2) (2014).

Mack, Natasha et al. "Barriers and Facilitators to Pre-exposure Prophylaxis (PrEP) Eligibility Screening and Ongoing HIV Testing among Target Populations in Bondo and Rarieda, Kenya: Results of a Consultation with Community Stakeholders." *BMC Health Services Research* 14.1 (2014).

Raphael, M.-C. "Microbicides Are Promoted as Offering a 'female-controlled' HIV Prevention Method: So Can They Revolutionize the HIV Crisis of Young Women in Kenya?" *Journal of Public Health* 34.4 (2012): 625-30.

Namey, Emily et al. "When and Why Women Might Suspend PrEP Use According to Perceived Seasons of Risk: Implications for PrEP-specific Risk-reduction Counselling." *Culture, Health & Sexuality* 18.9 (2016): 1081-091.
Corneli, Amy et al. "Motivations for Reducing Other HIV Risk-Reduction Practices If Taking Pre-Exposure Prophylaxis: Findings from a Qualitative Study Among Women in Kenya and South Africa." *AIDS Patient Care and STDs* 29.9 (2015): 503-09.

Corneli, Amy et al. "Participants' Explanations for Nonadherence in the FEM-PrEP Clinical Trial." *JAIDS Journal of Acquired Immune Deficiency Syndromes* 71.4 (2016): 452-61.

Ware, Norma et al. "What's Love Got to Do With It? Explaining Adherence to Oral Antiretroviral Pre-Exposure Prophylaxis for HIV-Serodiscordant Couples." *JAIDS Journal of Acquired Immune Deficiency Syndromes* 59.5 (2012): 463-68.

Celum, Connie L. et al. "Rethinking HIV Prevention to Prepare for Oral PrEP Implementation for Young African Women." *Journal of the International AIDS Society* 18.4 (Suppl 3) (2015)

Mansoor, Leila Essopm et al. "Impact of an Adherence Intervention on the Effectiveness of Tenofovir Gel in the CAPRISA 004 Trial." *AIDS and Behavior* 18.5 (2014): 841-48.

Nachega, Jean B. at al. "Antiretroviral Therapy Adherence, Virologic and Immunologic Outcomes in Adolescents Compared With Adults in Southern Africa." *JAIDS Journal of Acquired Immune Deficiency Syndromes* 51.1 (2009): 65-71.

Bekker et al. "HPTN 067/ADAPT Cape Town: a comparison of daily and non-daily PrEP dosing in African women." Conference on Retroviruses and Opportunistic Infections (CROI); 2015 Feb 23 26; Seattle, WA, USA. Abstract 978LB.

Harper, Cynthia C. et al. "Willingness of Clinicians to Integrate Microbicides into HIV Prevention Practices in Southern Africa." *AIDS and Behavior* 16.7 (2012): 1821-829.

Elst, Elisabeth Maria Van Der et al. "High Acceptability of HIV Pre-exposure Prophylaxis but Challenges in Adherence and Use: Qualitative Insights from a Phase I Trial of Intermittent and Daily PrEP in At-Risk Populations in Kenya." *AIDS and Behavior* 17.6 (2012): 2162-172.

Guest, Greg et al. "Acceptability of PrEP for HIV Prevention Among Women at High Risk for HIV." *Journal of Women's Health* 19.4 (2010): 791-98.

Dellar, Rachael C., Sarah Dlamini, and Quarraisha Abdool Karim. "Adolescent Girls and Young Women: Key Populations for HIV Epidemic Control." *Journal of the International AIDS Society* 18.2(Suppl 1) (2015).

Baxter, Cheryl, and Salim Abdool Karim. "Combination HIV Prevention Options for Young Women in Africa." *African Journal of AIDS Research* 15.2 (2016): 109-21.

Ngure, Kenneth et al. "I Knew I would be safer. Experiences of Kenyan HIV Serodiscordant Couples Soon After PrEP Initiation." *AIDS Patient Care and STDs*. 30.2 (2016): 78-83.

Greene et al. "Acceptability and Adherence of a Candidate Microbicide Gel among High-risk Women in Africa and India." *Culture, Health & Sexuality. U.S. National Library of Medicine*

Mmeje, Okeoma et al. "Perspectives of Healthcare Providers and HIV-affected Individuals and Couples during the Development of a Safer Conception Counseling Toolkit in Kenya: Stigma, Fears, and Recommendations for the Delivery of Services." *AIDS Care* 28.6 (2016): 750-57.

Withers, Melissa et al. "Men's Perspectives on Their Role in Family Planning in Nyanza Province, Kenya." *Studies in Family Planning* 46.2 (2015): 201-15.

Montgomery, Elizabeth T. et al. "Acceptability and Use of the Diaphragm and Replens® Lubricant Gel for HIV Prevention in Southern Africa." *AIDS and Behavior* 14.3 (2009): 629-38.

Haberer, Jessica. "Adherence to Pre-Exposure Prophylaxis in the Partners Demonstration Project: Preliminary Findings." *International Association of Providers of AIDS Care* 2014.

Stadler, Jonathan et al. "Hidden Harms: Women's Narratives of Intimate Partner Violence in a Microbicide Trial, South Africa." *Social Science & Medicine* 110 (2014): 49-55.

OPTIONS Knowledge, Attitudes and Practices of PrEP Providers Working With AGYW: A Review of completed, ongoing and planned studies. December 2016

SOURCES

THE COMPETITIVE SET

Raphael, M.-C. "Microbicides Are Promoted as Offering a 'female-controlled' HIV Prevention Method: So Can They Revolutionize the HIV Crisis of Young Women in Kenya?" *Journal of Public Health* 34.4 (2012): 625-30.

Dayton, Robyn, Michele Lanham, and Rose Wilcher. "Engaging Male Partners in Women's Microbicide Use: Evidence and Recommendations." *FHI 360*, 2014.

Mack, Natasha et al. "The Importance of Choice in the Rollout of ARV-based Prevention to User Groups in Kenya and South Africa: A Qualitative Study." *Journal of the International AIDS Society* 17.3(Suppl 2) (2014).

Domanska, Catherine A., and Anne M. Teitelman. "Factors That Affect Acceptance of HIV Microbicides among Women." *Collegian* 19.1 (2012): 23-32.

Celum, Connie L. et al. "Rethinking HIV Prevention to Prepare for Oral PrEP Implementation for Young African Women." *Journal of the International AIDS Society* 18.4 (Suppl 3) (2015).

Greene et al. "Acceptability and Adherence of a Candidate Microbicide Gel among High-risk Women in Africa and India." *Culture, Health & Sexuality. U.S. National Library of Medicine*.

Stadler, Jonathan et al. "Hidden Harms: Women's Narratives of Intimate Partner Violence in a Microbicide Trial, South Africa." *Social Science & Medicine* 110 (2014): 49-55.

Montgomery, Elizabeth T. et al. "Acceptability and Use of the Diaphragm and Replens® Lubricant Gel for HIV Prevention in Southern Africa." *AIDS and Behavior* 14.3 (2009): 629-38.

Woodsong et al. "Vaginal Ring Adherence in Sub-Saharan Africa: Expulsion, Removal, and Perfect Use." *AIDS and Behavior* (2012).

Nel, Annalene et al. "A Safety and Pharmacokinetic Trial Assessing Delivery of Dapivirine from a Vaginal Ring in Healthy Women." *AIDS* 28.10 (2014): 1479-487.