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EVIDENCE FOR HIV PREVENTION IN SOUTHERN AFRICA

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'Fellow Kenyans'

How Kenya achieved national HIV policy commitments for key populations by 2010

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> Although sex work, homosexuality and drug use are illegal in Kenya, and attempts to decriminalise them meet with popular resistance, this Plan, has evidence-based strategies to systematically remove constraints to reducing HIV transmission.
>
> Michel Sidibé, UNAIDS Executive Director,
> *writing on the launch of Kenya National AIDS Strategic Plan III (KNASP III) in January 2010*[3]

INTRODUCTION

In 2010, Kenya, a country with deeply conservative social values, became the first in Africa to formally acknowledge the importance of key populations – men who have sex with men (MSM), sex workers and people who use drugs (PWID) – in its national policy response to HIV. Initially, this was done by making all three key populations central to a new national AIDS strategy – *KNASP III.*[4] Later in 2010, Kenya published the *National Guidelines for HIV/STI programs for Sex Workers (2010),*[5] a critical publication because it was the first national policy in Africa to focus exclusively on a key population (KP) in relation to HIV and AIDS. Furthermore, representatives of MSM organisations were involved in the development of these guidelines and the language used deliberately references MSM and PWID as a means of acknowledging their importance under the cover of the sex-worker theme. Consequently, the guidelines were widely regarded as a document supporting work with all key populations.

Although the guidelines focused on sex workers, together with the KNASP III commitments they opened space and availed access to funding for the growth of MSM and PWID organisations, and, moreover, created a 'safe space' for key populations to operate despite being criminalised. These specific policy commitments were crucial for the growth of key population organisations that are part and parcel of the improved HIV service delivery to key populations in Kenya today. This happened despite widespread antagonism towards sex workers, MSM and drug users in an environment in which sex work, homosexuality and intravenous drug use remained illegal.

This case study seeks to understand the change process towards the launch of KNASP III and particularly the guidelines for sex workers through attention to three questions:

1. Why was Kenya the first country to develop and publish a policy for a key population?
2. How did the very varied stakeholders push this change process in an otherwise culturally conservative social context?
3. Why were sex workers the initial key population in focus?

To answer these questions the study develops an understanding of the context for the changes and then maps out the chronology of the change while drawing attention to key developments and their significance. It highlights the critical roles of evidence from research, political will, courageous leaders, early adoption of international best practice and grassroots organisations in a time of general willingness to reform institutional practice. It then reflects on the characteristics of the different actors and key factors that contributed to the changes.

3 Kenya National AIDS Strategic Plan III. A new dawn in AIDS programme planning and implementation. *Daily Nation* (Nairobi) Tuesday 12 January 2010 (26, 33)

4 National AIDS Control Council, Kenya. *National AIDS Strategic Plan 2009/10-2012/13. Delivering on universal access to services.* Nairobi, 2009

5 Ministry of Public Health and Sanitation, Kenya. *National Guidelines for HIV/STI programs for sex workers*. Nairobi, 2010

About this paper

This paper is part of the series, *Included! How change happened for key populations and HIV prevention*, commissioned by EHPSA to the Nordic Consulting Group. The full series of nine case studies and discussion paper will be made available on the EHPSA website as they are completed at **http://www.ehpsa.org/critical-reviews/included**.

The series was based on literature research and on interviews with key actors. It focuses on examples from eastern and southern Africa. In-depth interviews for this case study were conducted with representatives of the Kenyan government, researchers and leaders of organisations that represent sex workers and LGBTI people. Prisoners and PWID organisations did not play a significant role in this case study; this reflects the key-population focus in Kenya. The full list of interviewees is given in Appendix 1 on page 15.

About EHPSA

Evidence for HIV prevention in eastern and southern Africa (EHPSA) is a catalytic intervention, contributing to national, regional and global processes on HIV prevention for adolescents, men who have sex with men (MSM) and people in prison, through generating evidence of what works and why and developing strategies to inform policymaking processes. EHPSA is a five-year programme funded by DFID and managed by Mott MacDonald.

2. CONTEXT

Kenya has a population of 41 million people[6] and has the fourth-largest HIV epidemic in the world in terms of the number of people living with HIV. The first Kenyan case of AIDS was detected in 1984 and by the mid-1990s it was one of the major causes of mortality in Kenya, which placed huge demands on the health-care system and the economy.

The country has made great strides in HIV prevention and ART provision.

Although Kenya has a generalised epidemic that affects all sectors of the population, there is a concentration of high HIV infection among key populations, especially in certain parts of the country. In stark contrast with the HIV prevalence of 5.6% in the general population in 2012, recent surveys indicate prevalence of 29.3% amongst sex workers,[7] 18.3% amongst PWID[8] and 18.2% amongst MSM.[9]

With the largest economy in the region and functional government institutions, Kenya is the political driver in East Africa. The HIV response has been led by two institutions: the National AIDS Control Council (NACC) and the National AIDS and STI Control Programme (NASCOP), which is situated within the Ministry of Health. Kenya is the international hub of the East African region and hosts UN regional headquarters, a large diplomatic community and regional NGO offices. PEPFAR and the Global Fund have provided the main financial support to the national HIV response, whereas WHO, UNODC, UNAIDS and bilateral aid agencies have provided technical assistance and comparatively small levels of funding.

Across Kenya there is widespread cultural conservatism towards homosexuality and consequential negative attitudes towards MSM. According to Kenyan legislation, homosexual practice is illegal and subject to severe punishment; the penal code provides for a prison sentence of up to 14 years. However, the legislation is not straight-forward and no one has yet been convicted for homosexual practice.

Although sex work is also illegal there is an assumption that it is strongly associated with poverty, which means that sex workers are viewed differently and more sympathetically than MSM.

6 Official estimate, 2011

7 National Key Populations Programme, NASCOP, Ministry of Health, Kenya. *2010–2011 Integrated biological and behavioural surveillance survey among key populations in Nairobi and Kisumu, Kenya.* Nairobi, 2014.

8 National Key Populations Programme, 2014

9 National Key Populations Programme, 2014

There is a vibrant civil society of international and national NGOs and increasingly vocal and competent key population organisations, especially among sex workers and MSM and LGBTI. Kenya also has strong academic institutions that have been involved in cutting-edge research on HIV since the early days of the epidemic. This has contributed to shaping the response to the epidemic in Kenya. Since it began in the 1980s, epidemiological research has focused on sex workers. This study will demonstrate that this scholarly attention to one key population made a significant contribution to the launch of the national guidelines in 2010.

Although the abovementioned contextual factors have shaped Kenya's approach to key populations, political developments since 2000 have also had an important influence. The peaceful hand-over of power to the opposition after the 2002 general election and the review of the 1963 constitution gave hope for change. The unprecedented violence after the 2007 general elections, however, left hundreds dead and thousands displaced. The violence shook many Kenyans who never imagined their country could entertain the type of inter-ethnic conflict they had condemned elsewhere in the region. In response, in 2008 and 2009, political discourse focused on reconciliation, peace and inclusivity. In a shift of attitudes, Kenyans began to view members of key populations as fellow Kenyans with specific needs, rather than individuals with identities they disapproved of.

In 2010, Kenyan voters approved a new constitution with a strong orientation towards democratic values, social justice and human rights. Significantly, the new constitution entrenches health rights without discrimination for all citizens. Since the promulgation of the new constitution in August 2010, policy-making has been more progressive in relation to marginalised populations, which reflects changing perceptions and acknowledgement of shared rights.

It is thus clear that the policy process being examined here took place during a period of Kenyan history that was marked by willingness to reform government operations in relation to key populations.

3. THE CHANGE PROCESS

In 2010, Kenya made strong policy commitments relating to key populations and HIV by publishing two documents – *KNASP III,* with its clear acknowledgement of MSM, sex workers and PWID; and, the *National Guidelines for HIV/STI programs for Sex Workers*. Their significance for Kenya's HIV and AIDS prevention programme is captured in the book *Reaching the Unreached. The Evolution of Kenya's HIV Prevention Programme for Key Populations,*[10] which begins:

> This is a story of how a disparate group of courageous and dedicated medical and social scientists, key population and human right advocates, development agency personnel, and government officials risked disapproval and worse from peers, employers, and the public to conduct research and implement programmes to ensure that everyone, regardless of their behaviour or sexual orientation, receives equal and unprejudiced access to HIV prevention care, and treatment. [It] also describes the political and social environment that formed the backdrop for planners and public health administrators as they charted a new course for programmes dealing with key populations.[11]

This case study seeks to understand the contributions to policy development of many and varied stakeholders in an otherwise culturally conservative social context. The process is described chronologically in four phases starting with the advent of AIDS in Kenya in the 1980s, with attention to key occasions that contributed to the changes.

From denial to government action (1980–1987)

The first case of AIDS was officially confirmed in Kenya in 1984. The University of Nairobi's Department of Medical Microbiology had initiated collaboration with international scholars from Canada, the USA and Belgium concerning an alarming rise in sexually transmitted diseases. Researchers working with sex workers with a high

10 NASCOP, Kenya. *Reaching the Unreached. The Evolution of Kenya's HIV Prevention Programme for Key Populations* Nairobi, 2016

11 NASCOP 2016: 2, author's emphasis

burden of other STIs carried out HIV tests on a group of sex workers in Majengo, a low-income neighbourhood on the outskirts of Nairobi, and on a smaller cohort in downtown Nairobi. Two out of three women tested positive for HIV – irrefutable scientific evidence that HIV could be transmitted through heterosexual encounters.

These findings proved that Kenya had the beginnings of an epidemic that the Kenyan establishment had until then denied. When the researchers in Nairobi discussed details of the study with the British newspaper *The Guardian*, they were threatened with deportation by an official. The actions of the late Elizabeth Ngugi, the then chief nursing officer in the Ministry of Health, calmed things down. 'I explained that it wasn't their doing. This was science they were reporting, a search for truth,' she said later.[12]

At the time, Ngugi was conducting doctoral research at a clinic that treated STIs among sex workers in Majengo. She organised more than 600 sex workers into support groups, taught them about STIs, distributed condoms and encouraged them to unite in insisting on protected sex.[13]

Perhaps it was the news about HIV from Uganda, Tanzania, then-Zaire and other countries in the region combined with evidence produced by local scientists that led the government to recognise the HIV epidemic in the country and embark on preventive action. In 1986, Kenya became the first African country to officially report AIDS to the World Health Organization (WHO).

In 1987, the Kenyan Ministry of Health established the National AIDS and STIs Control Programme – NASCOP – to lead national efforts to manage and control STIs and HIV. Backed by the findings of the Majengo-based studies, NASCOP began to formulate policies and programmes in line with the then widely accepted evidence that unprotected heterosexual contact was the main driver of the epidemic. There was no mention of homosexuality which was regarded as a western phenomenon that did not exist in Kenya.

Building evidence for action (1990–2008)

Initial collaboration between the University of Nairobi and western universities on STIs expanded to include not only research on the modes of transmission and natural history of HIV and AIDS but also to meet the urgent demand for methods to prevent HIV transmission. Sex workers and other populations with multiple sexual partners, such as long-distance truckers, were among those who attracted the attention of researchers because of their high rates of infection and transmission.

The University of Nairobi and the University of Manitoba, Canada, started a project entitled Strengthening STD/AIDS Control in Kenya that was to become critical to Kenya's HIV-prevention programming and policies; the project findings have influenced global changes in the therapeutic choices of STDs. The Canadian International Development Agency (CIDA) awarded the programme 15 years of funding. In 2000, the International Centre for Reproductive Health (ICRH) established by the University of Ghent, Belgium, established drop-in centres for sex workers in Mombasa for HIV service delivery and action-based research, and in Kilifi, north of Mombasa, the Kenya Medical Research Institute (KEMRI), the Wellcome Trust and the International AIDS Vaccine Institute (IAVI) set up a research project with a cohort of sex workers in 2005.

In the early 2000s, researchers and health workers in Coast Province and Nairobi also began to make contact with the undocumented Kenyan MSM population. A couple of small studies were carried out in Nairobi and Kilifi, and in 2003 the Population Council embarked on Kenya's first behavioural studies among MSM in Nairobi and Mombasa. The research institutes also collaborated on studies; between 2006 and 2008 KEMRI, the Population Council and ICRH did a pre-and post-intervention behavioural study of male sex workers in Mombasa.

All the studies had similar key conclusions. Sex workers and MSM had a relatively high HIV prevalence (up to 25%) and were not able to access prevention, counselling and care appropriate to their needs at ordinary clinics. Besides concerns about the limited access of sex workers and MSM to health information and services, it was found that 30 to 40% of MSM in the studies had sexual relationships with women. One principal recommendation was that effective HIV prevention interventions tailored specifically for MSM were critical to curbing HIV transmission not only among the key population but also in the general population.[14]

12 This section draws heavily on the aforementioned book and on interviews with key stakeholders.

13 This model of organizing support groups and hiring the members of the key population as peer educators has been accepted globally as a best practice in working with disadvantaged and stigmatized populations.

14 NASCOP 2016: 20

In Geneva, UNAIDS epidemiologists developed a model to approximate HIV incidence that required a large, systematic dataset. In 2008, the model was piloted in four African countries with sufficient data – Kenya, Uganda, Zambia and South Africa. UNAIDS and the World Bank funded the so-called Modes of Transmission (MoT) study, which was carried out in a collaboration between UNAIDS and research institutes in Kenya with oversight from the NACC. The MoT study[15] became a turning point; then head of NASCOP, the operational arm of the national AIDS council, Dr Nicholas Muraguri,

> … [s]eized the opportunity to place key populations in the forefront of the response by including them in the survey. For the first time in the history of the Kenyan AIDS epidemic, a national government survey was published that included data on key populations. It was a watershed moment. Official statistics had made a connection between key populations and rapid HIV transmission.[16]

Another study conducted in 2007, the Kenya AIDS Indicator Survey[17] (KAIS), demonstrated that although there had been a significant decline in the general HIV prevalence there was a high HIV prevalence among key populations. To add to this finding from the KAIS, three findings from the MoT study (which tried to measure incidence – where the new infections were originating) were particularly salient:

1. A disproportionately high number of new HIV infections were among key populations despite their small population size: of total new infections, sex workers and their clients contributed 14%, MSM and prisoners, 15% and PWID, 4%. Although these groups made up just 2% of the general population, they accounted for 33% of new HIV infections.
2. The study showed a bridge to the general population and thus high risk of infection beyond the MSM community, particularly since 60% of Kenyan MSM were bisexual, with many in heterosexual marriages.
3. Key populations were grossly underserved by the national HIV response.

It was important that the NACC played a leading role in providing oversight and that state universities led the research. This meant the study was regarded as official and the government owned the results from the outset. The MoT provided the first hard evidence in a government study on HIV infection of the existence of a bridging population from a key population to the general population. It triggered a paradigm shift in Kenya's approach to the AIDS epidemic as NASCOP assumed leadership and spoke openly about HIV and the role of key populations such as sex workers and MSM.[18]

The national strategic framework at the time – the *Kenya National AIDS Strategic Plan 2005/06 – 2009/10* (KNASP II) – had initiated HIV prevention programming for populations at elevated risk for HIV but the programmes were not coordinated. Furthermore, because the outcomes for key population programmes were not clearly incorporated into the national monitoring and evaluation framework, tracking the results from the period between 2005 and 2008 was difficult.

The National AIDS Control Council, in collaboration with the development partners (UNAIDS, CDC, PEPFAR and DFID) and the research partners, decided to cut short the KNASP II and develop a new strategic plan (KNASP III) along with guidelines to better reach key populations with behavioural, biomedical and structural interventions. In this way, the findings of the MoT and KAIS studies provided a technical basis for the prioritisation of these key populations for interventions in the 2009–2013 Kenya National AIDS Strategic Plan (KNASP III) and for the development of the national guidelines for HIV programming for sex workers.

15 National AIDS Control Council, Kenya. *Kenya HIV Prevention Response and Modes of HIV Transmission Analysis*. Nairobi, 2009.

16 NASCOP 2016: 24

17 NASCOP, Kenya: *2007 Kenya AIDS Indicator Survey: Final Report*. Nairobi. September 2009.

18 NASCOP 2016: 25

The key population programme and emergence of key population organisations (2008–2010)

NASCOP worked with the research institutes described in the previous section to promote evidence-based programming for key populations. From Dr Muraguri's perspective, the scientific evidence from the MoT study provided a window of opportunity to launch a national key populations (KP) programme under the leadership of NASCOP. Muraguri was one of few civil servants in key positions to acknowledge the changing national mood. He used his status to foster a growing sense that *all* Kenyans should have an equal right to health care. The start of this KP programme was a turning point because, ahead of the launch of formal national policy, it put key populations at the centre of the national HIV and AIDS programme – both as a concern and as partners.

The programme was placed under the leadership of Helgar Musyoki and was received with great enthusiasm by stakeholders. No less than 190 people, from ministers to members of key populations, attended the launch meeting in mid-2009. The programme, dubbed Closing the Tap, was launched on 7 July – Saba Saba Day – a date marked by calls for freedom from rights abuses since 1990. The donor community financed KP programme operations, which included development of guidelines for key populations and evidence-generation to inform programming.

A first task was to form a technical working group (TWG) for key populations and Musyoki and her team invited sex workers, MSM and PWID to join alongside government officials and people from NGOs, research institutes and donor agencies.[19] The TWG met every quarter; in an interview in 2016, Musyoki said it had done so for the past eight years. The establishment of this forum has been crucial for the regular interaction between various stakeholders. As we shall see in the next section, the TWG was the driving force behind development of critical policy documents.

A second significant achievement was the empowerment of KP organisations. NASCOP had worked with key population organisations since the early 2000s, yet the KP programme greatly enhanced its ability to respond to the needs of mushrooming organisations for capacity-building to engage in HIV prevention and improve access to service delivery.

Although public awareness about HIV was growing, key populations still faced discrimination and seldom used ordinary health clinics. A 2008 study in Mombasa found that when outreach was run by trusted peers, the use of condoms by sex workers and their clients increased significantly. The University of Nairobi and the University of Manitoba saw the sense in this and started the Sex Workers Outreach Programme (SWOP) in Nairobi, which built upon its experience of training sex workers as peer educators to conduct research. It also set up support groups for sex workers and provided customer friendly STI/HIV education and clinical services initially to 2 600 sex workers.[20] An estimate of the female sex worker population carried out by universities in central Nairobi indicated that there were about 7 000 female sex workers in the central business district alone. Further surveys estimated that the total female sex worker population of Nairobi was at least five to six times greater.

SWOP contributed to the nascent groundswell of civil society activism. Soon after the first SWOP clinic opened to female sex workers, a group of male sex workers also began to seek treatment there and was welcomed. The same peer-led approaches that had worked for female sex workers were applied to their male counterparts.

For John Mathenge, a school dropout who had chosen to do sex work at coastal resorts and was a passionate advocate for the health issues of MSM and sex workers, the job at the SWOP clinic in downtown Nairobi became a stepping stone for setting up Health Options for Young Men on HIV, AIDS and STIs (HOYMAS), an important KP organisation to this day. He was open about his HIV-positive status and promoted the view that people living with HIV are the best candidates to implement programmes in their communities. HOYMAS is one of several NGOs, along with ISHTAR and others, that are working with the local MSM community.

The emergence of sex worker key population organisations to provide services reflected global best practice, and donors were thus willing to provide financial support. The Kenya Sex Workers Alliance (KESWA) and The Bar Hostess Empowerment and Support Programme (BHESP) were among organisations formed by sex workers to

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20 The SWOP Program now has more than 10 000 sex workers in care, and has reached over 30 000 through its hotspot-centred outreach work

strengthen their right to care and advocate for a supportive legal framework. Government and donor funding of KP organisations contributed to the change process by empowering key population communities, reducing stigmatisation and discrimination and improving access to HIV services. The official support also boosted confidence in the key population programme and with time, NASCOP in partnership with the TWG, made great efforts to win over religious leaders, the media and law makers.[21]

Development and launch of KNASP III and the National Guidelines for HIV/STI programs for Sex Workers (2010)

The Technical Working Group was tasked with designing key population interventions for KNASP III and formulating national operational guidelines to reflect the policy positions in KNASP III, including the National Guidelines for HIV/STI programs for Sex Workers. It was the first time a national strategy acknowledged the importance of targeting key populations as part of HIV prevention efforts; for the first time, there was to be a set of operational guidelines focussing on a key population. The justification for this was clear from the research in Kenya and what was becoming established as international best practice. And yet, as the statement from UNAIDS Executive Director, Michel Sidibé highlighted, the reality was delicate due to the absence of an enabling legal and policy environment in the face of popular resistance; in particular, sex work, homosexual practice and drug use remained illegal. However, persistent 'technical champions'[22] pushed to get key populations prioritised in strategic documents – KNASP III and Global Fund proposals – which then created the policy precedent for the operational guidelines. They also wisely secured public support from high profile figures.

The technical champions came from various stakeholder categories: Dr Nicholas Muraguri and Helgar Musyoki from NASCOP, Dr Joshua Kimani and Dr Larry Gelmon from the University of Nairobi/University of Manitoba collaboration; and, Peninah Mwangi, director of the sex worker organisation BHESP. Their advocacy drew upon established international best practice as well as the evidence generated in Kenya and Kenya's tradition of being an early adopter. During the 2000s, there was significant focus from international bodies, such as UNAIDS, on MARPs – most at risk populations – and then on the role of transactional sex in the spread of HIV. The focus on MARPs supported the prioritisation of the key populations, while the focus on sex workers reflected an emerging emphasis in international best practice.

The champions were also astute. The KP programme gave sex workers and MSM organisations direct influence on Kenya's proposals to the Global Fund by making them members of the inter-agency Coordinating Committee on HIV, which is the technical forum for the Global Fund in Kenya. The successful 2010 Global Fund application then provided a funding endorsement and in practical terms was used to obtain funding independent from government for particularly sensitive inputs such as water-based lubricants used by MSM.

Meanwhile, high profile figures were used to promote the policies – then Prime Minister Raila Odinga launched KNASP III, with UNAIDS Executive Director Michel Sidibé in attendance.

The first guidelines demonstrated an understanding of differing public attitudes to both sex workers and MSM. Even though the guidelines were specifically for sex workers, who were viewed more sympathetically, they incorporated language that endorsed key populations more generally. In this way, what was regarded as a key population policy document was launched under the cover of sex work.

The work itself was highly collaborative. During 2010, the TWG led the planning, drafting, editing and reviewing of the national sex worker guidelines and involved many other stakeholders from the wider research community, key population organisations and international donors. The CDC provided the financial and technical support and the University of Nairobi/University of Manitoba hosted the secretariat for the policy development.

At times this process was met with great resistance. In early 2010, a volunteer in a KEMRI-managed research clinic in Coast Province was severely beaten by an angry mob. The incident prompted greater emphasis on community engagement and education about key populations. Some months later, NASCOP and UNAIDS organised the first national symposium for key populations in Mombasa. The Minister for Special Programmes,

21 NASCOP 2016: 27

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the Hon. Esther Murugi, was the first government minister to attend a meeting with key populations and this led to calls for her resignation. However, the furore soon died down. Also in 2010, a delegation of key populations joined the Minister for Health, Hon. Beth Mugo, at the UNAIDS Summit in New York. The ministers' public support for key populations made external work much easier.

4. HOW CHANGE HAPPENED

Despite abiding social conservatism concerning sex work and homosexuality, coupled with an adverse legal position, Kenya was the first country in Africa to make key populations central to its national AIDS policy, and to publish formal guidance on interventions with one key population – sex workers. This case study has highlighted the critical roles of evidence from research, political will, courageous leaders, early adoption of international best practice and grassroots organisations in a time of general willingness to reform institutional practice. This section summarises the specific actors and the critical factors which enabled these achievements to be realised.

4.1 Actors

Many actors were involved through different positions and actions, as Table 1 below shows:

Actor category	Role	Key actions
Research institutions	Critical role throughout the change process in delivering research evidence, providing services and helping nascent KP organisations to develop.	Knowledge production, intervention research and networking with government, international actors, and KPs.
National government (esp. National AIDS Control Council; NASCOP)	Critical role in most of the change process	Political will to put evidence into action; worked with all stakeholders to attain this.
Key population organisations	Important role in the policy development, drawing on experiences of providing services as organisations and using services as individuals	Emerged during the process and played an active role in the policy development
Individuals/champions of change	Critical role throughout the change process	Provided leadership for change, were astute and demonstrated perseverance in managing engagement with different stakeholders. Courage to take 'daring' actions that may have cost them their position or led to stigmatisation.
Global actors e.g. UNAIDS and WHO	Critical role throughout the change process (funding and policy, particularly support to best practice.)	Led the development of KP policies at global level and of ground-breaking studies, which led to the focus on Key Populations in HIV work globally
Human rights and development NGOs	No active role	N/A

4.2 Contributing factors

In identifying critical factors contributing to the achievements, a distinction is made between those that created an enabling environment for change and the tactics used to bring about change in this context. Inevitably, there is some overlap of these.

Creating an enabling environment

- **Quality evidence available**

The continuous production of internationally recognised scientific knowledge on HIV amongst sex workers, and later, MSM, attracts top scholars from Kenya and beyond to further expand knowledge and interventions. Most research has been funded by international donors and has involved collaboration between respected Kenyan and western institutions. It is also aimed at being relevant for both academic and applied purposes. It has provided epidemiological knowledge, size estimations and knowledge on stigma and discrimination to access health, legal and social services.

- **Evidence-based practice in government departments**

Senior policy-makers demonstrated an expectation that the latest evidence should be reflected in policy development and implementation, as in the example of the findings of the MoT study. There were several reasons for this:

1. Global exposure and high academic level of Kenyan policy makers ('Cabinet ministers can understand academic evidence').
2. Government leaders in key positions have worked within civil society ('They know what is happening on the ground').
3. The distinctive situation of relevant departments of the University of Nairobi which as a state university is effectively the research wing of the Ministry of Health, with an expectation that policymakers will take an active interest in research and researchers will share emerging results to shape policy.
4. The strong presence of UN bodies and development partners in Kenya, including the UNAIDS regional centre and links with international experts who have maintained personal connections.

- **Research institutions expected to engage on findings**

Research institutions have engaged beyond knowledge generation, for example, they have been involved in evidence-based advocacy for actions based on research and have actively participated in the TWG for key populations.

- **Catalytic events**

The crisis following the post-election violence of 2007 provoked a new spirit of tolerance and inclusiveness. It was a time of general willingness to see things differently, to reform institutional practice and to accept members of key populations as fellow Kenyans. Constitutional reform reflected this by entrenching health rights for citizens without discrimination.

The key findings from the MoT study – the significant contribution of key populations to HIV infection across Kenya, the bridge to the general population and high risk of infection beyond the MSM community, due to 60% of Kenyan MSM being bisexual and the absence of members of key populations from the national HIV response – provided a technical jolt to HIV prevention programming at this time of greater openness to inclusion.

- **Influential champions**

Inspiring individuals showed competence, innovation, courage, dedication and political wisdom in pursuing progressive positions and reading opportunities. Many of these were highly placed, influential leaders. The national context, as described above, was conducive for dedicated individuals to be courageous and speak out positively about and with otherwise stigmatised populations.

- **Technical working group established and sustained**

The establishment of and commitment to the TWG provided a vehicle for ongoing discussion and action involving government, donors, research institutions, NGOs and KP organisations representing affected communities.

- **External funding available**

The continuous funding made available by international agencies for research, policy-making, and intervention meant that the change process could move ahead. International funding for the HIV response in Kenya, including to key populations, is among the highest in the regional per person living with HIV.

• **Global policy available for adoption**

Ongoing policy-making of UNAIDS and WHO, especially, has been conducive for the dynamic response to the epidemic in Kenya. Kenya's early adoption of global policy is related to the heavy UN presence in Nairobi, including the UNAIDS regional centre and the Kenyan 'tradition' of leading the adoption of international policies within the region. During the first decade of the new millennium, there was a lot of focus on the role of transactional sex in the spread of HIV; in 2005 WHO introduced a toolkit for targeted HIV/AIDS prevention and care in sex-work settings[23] and in 2009 UNAIDS published a guidance note on HIV and sex work.[24]

• **Civil society organisations present – with the capacity to respond**

The declaration of AIDS as a national disaster in 1999 created a political space for key populations to organise and register associations. Women involved in sex work recognised the need to register their own associations as a new kind of women's organisation. Research organisations that had developed small-scale sex-worker groups for data collection enabled them to grow into service providers. A few strong organisations, especially in Nairobi, grew from small community-based organisations to larger entities with capacity to run donor-funded programmes on empowerment, peer-educator approach, condom distribution, etc. This was further aided by funding from the key population programme, for capacity-building and implementation.

By 2009, female and male sex-worker organisations and MSM organisations had sufficient capacity and visibility to advocate for their rights and recognition, whilst astute champions within government gave them platforms from which to influence, for example, through the key populations TWG and the technical forum for the Global Fund in Kenya.

The progressive Bill of Rights in the new 2010 constitution and the continued expansion of health services to marginalised communities, including MSM and PWID, provided an opportunity for other organisations associated with KPs to emerge, build capacity and gain visibility. The key population programme provided initial funding and capacity building until the organisations became eligible for international aid funding.

Tactics used to bring about change

The tactics that were employed included many that one would expect in a successful advocacy strategy:

• **Wise leadership applied politically astute approaches**

Bringing about change for key populations, especially sex workers and MSM, in a conservative culture with legal constraints, requires sensitivity and acumen, for example, in terms of taking strategic opportunities, framing arguments for better acceptance, deploying champions and winning over opponents. There are numerous examples of this in the processes leading to the successful launch of the policies:

- The head of NASCOP in 2008, Dr Nicholas Muraguri, introduced key populations into the UNAIDS-sponsored MoT study to obtain information on their specific contributions to HIV infection in Kenya. He then recognised that the key study findings, coupled with a growing national mood of tolerance and inclusion, presented a strategic opportunity to promote support to key populations in the national HIV response. Given the time that policy development takes, he bolstered support initially by launching the KP programme in 2009 to build the capacity of key population organisations, with the policy documents following in 2010.

- The findings of the MoT study were recognised as an opportunity to frame the argument for support of key populations in terms of their significant and disproportionate contribution to HIV infection in the general population. Constitutional reforms were used to frame support in terms of the rights of citizens to health care without discrimination.

- High profile personalities were deployed to demonstrate support for the key population agenda – then prime minister, Raila Odinga, launched the KNASP III and health minister, Beth Mugo, was accompanied by a delegation of members of key populations to an UNAIDS summit in New York. Interestingly, in the full-page advertorial placed in national newspapers for the launch of KNASP III, it was the message from UNAIDS Director, Michel Sidibé, that introduced the key population dimensions of the strategy.

23 *Toolkit for targeted HIV/AIDS prevention and care in sex work settings.* Geneva, WHO, 2005.

24 *UNAIDS guidance note on HIV and sex work.* Geneva, UNAIDS, 2009.

- The focus on sex workers in the first national guideline produced for HIV/STI programming for a key population is reported to have been a calculated choice reflecting the fact that female sex workers were viewed more sympathetically than MSM. Through incorporating language that endorsed key populations more generally, what was widely seen as a document pertaining to all key populations was launched under the cover of a document relating to sex workers, for whom there would be less resistance.

- **Persistent and sustained commitment**

The process that is mapped out illustrates that 'influencing is usually a marathon, not a sprint.'[25] Critically, many leaders have remained engaged in influential positions for a number of years, e.g. the current Key Population Programme Manager began the programme in 2008; researchers who began HIV research on sex workers in the 1980s continued to be involved.

- **Civil society took opportunities**

Civil society organisations played an important role in this change process:

- **Research institutions, both local and international,** were essential throughout the change process. At first, the research institutions generated the basic evidence that led Kenyan authorities to acknowledge that the country had an AIDS epidemic. Later the research institutions worked to address knowledge gaps, engaged with opportunities such as the UNAIDS MoT study and collaborated with government departments by participating in government-led platforms.

- **Key population organisations**, in particular for sex workers and MSM, used their emergent capacity and visibility to advocate for their rights and recognition and became part of key forums such as the key population Technical Working Group and the team that developed the guidelines. In doing this, they played into three areas of distinctive competence:

  1. **Community mobilisation:** Research institutions, governments and donors have great difficulty in reaching key populations due to their secretive nature. Key population organisations could provide access via networks, channel information and mobilise community members.

  2. **Representation of constituency**: KP organisations represented their respective constituencies at local, national, and international levels for advocacy, policy-making and programming.

  3. **Insider knowledge**: KP organisations have insights into attitudes to HIV prevention, sexual practices and the needs of their constituencies. These are extremely difficult for outsiders to access due to limited trust and access.

4. CONCLUSIONS

Kenya's publication of the KNASP III in which key populations were central to the new national AIDS strategy, followed by the National Guidelines for HIV/STI programs for Sex Workers in 2010, were significant developments for the advance of HIV prevention among key populations. The publications strengthened access to funding for the growth of MSM and PWID organisations, as well as sex-worker organisations, and, moreover, created a 'safe space' for key populations to operate, despite being criminalised.

The journey to this point was a long one, with critical contributions from research institutions, national government structures, emerging key-population organisations, and global organisations. Champions of change from each of these backgrounds played important roles. Over time, a range of factors came together to create the environment in which these developments were possible. These included the availability of quality evidence from researchers committed to engage, and government structures that expected to utilise such evidence in developing policy; the emergence and early adoption of global policy that was supportive, and associated external funding for research and implementation; the growing strength of key population organisations, and wise and courageous leadership that persisted in its commitment.

Underlying all this was a shift in attitudes that followed the desire for reform and was accelerated when the

25 Tilley et al. *Ten things to know about how to influence policy with research*. London, ODI. January 2017

post-election violence of 2007 shook many Kenyans. With this, Kenyans began to view members of key populations as fellow Kenyans with specific needs, rather than individuals with identities they disapproved of, creating the opportunities stemming from the progressive and inclusive constitution adopted in 2010.

Appendix 1: Concluding Note on Methodology – Interviewees

The case study draws on document review and a number of interviews.

Interviewees included:

Larry Gelmon, Programme Head, University of Nairobi and University of Manitoba; Team Lead on Modes of Transmission (MoT) study, 2008

Grace Kamau, Coordinator, Key Population Consortium

Dr Nduku Kilonzo, Director, National AIDS Control Council

Joshua Kimani, Project Director, SWOP Programme, University of Nairobi and University of Manitoba

Helga Musyoki, Key Population Programme Manager, National AIDS and STI Control Programme

Peninah Mwangi, Director, Bar Hostess Empowerment and Support Programme (BHESP)

Daniel Peter Onyango, Director, NYARWEK (LGBTI-organisation in Western Kenya)

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