AMSHeR

African Men for Sexual Health & Rights

KENYA

THE MSM HEALTH SCORECARD

THE INITIATIVE FOR EQUAL RIGHTS

POSITIVE ACTION

AIDSAccountability International

CONTENT

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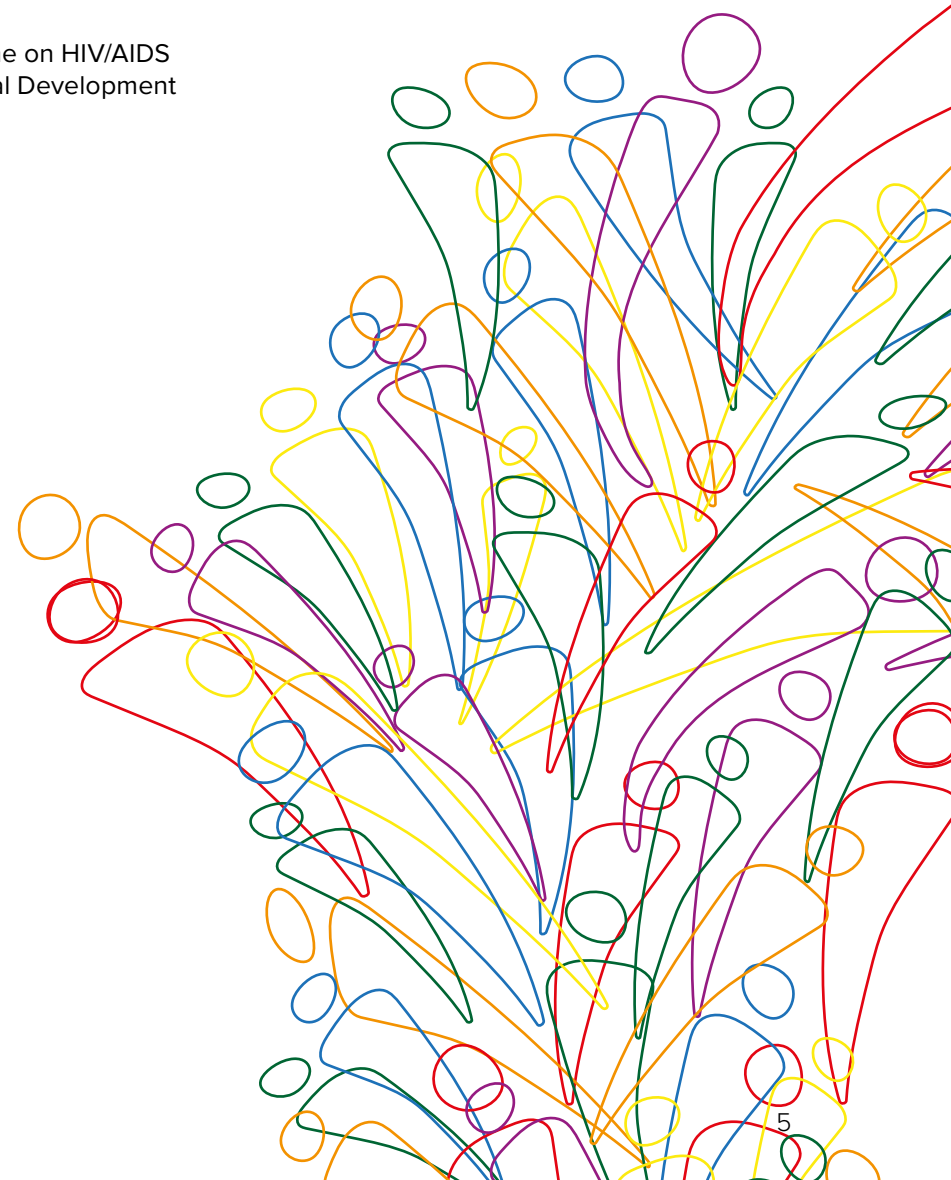
ABBREVIATIONS AND ACRONYMS

AAI Aids Accountability International
AIDS Acquired Immuno-Deficiency Syndrom
AMfAR American Foundation for Aids Research
AMSHeR African Men for Sexual Health and Rights
CDC United States Centers for Disease Control and prevention
CSO Civil Society Organisation
GFATM Global Fund against Aids Tuberculosis and Malaria
GALCK Gay And Lesbian Coalition of Kenya
HIV Human Immunodeficiency Virus
IAVI International Aids Vaccine Initiative
KANCO Kenya AIDS NGO Consortium
KNASP Kenya National AIDS Strategic Plan
KNASF Kenya National AIDS Strategic Framework
LGBTI Lesbian, Gay, Bisexual, Transgender, Intersexual
MARPs Most-At-Risk Populations
MDG Millennium Development Goals
M & E Monitoring and Evaluation
MHAP Men's Health Advocacy Project
MSM Men who have sex with men
NASCP National Aids & STI Control Programme
NCPI National Composite Policy Index
ND No Data submitted
NGO Non Government Organisation
NOPE National Organisation of Peer Educators
PEPFAR President's Emergency Plan For Aids Releaf
SOGI Sexual Orientation and Gender Identity
SRHR Sexual Reproductive health Rights
STI Sexually Transmitted Infection
UNAIDS The Joint United Nations Programme on HIV/AIDS
USAID United States Agency for International Development
WHO World Health Organisation



ABOUT THE ORGANISATIONS

The African Men for Sexual Health and Rights (AMSHeR) is a regional coalition of 18 MSM – and LGBTI-led organisations in 15 African countries established in 2009 by to i. address the disproportionate effect of the HIV epidemic on MSM and LGBTI; ii. the human rights violations these populations face on the continent; iii. and to increase the visibility of MSM/LGBTI issues across all levels of policy and service delivery at global, regional and local levels. AMSHeR was formed in an attempt to devise 'home-grown' strategies to address local issues. Through advocacy and capacity-strengthening, AMSHeR works towards achieving its mission of 'a healthy and empowered MSM community in Africa and human rights for all'. Although AMSHeR's formal membership is 18 organisations, strategically chosen to maintain geographic (Central, East, Southern and West Africa), linguistic (English, French, Kiswahili and Portuguese-speaking countries), socio-legal (common law, civil law and Roman-Dutch legal systems) representation of sub-Saharan Africa, AMSHeR maintains a reach across the whole of Africa through partnerships with a network of affiliate members.

AIDS Accountability International (AAI) was established in 2005 with the mission to follow up on commitments to the AIDS epidemic that were made by governments. Our work has since expanded to sexual and reproductive health and rights, malaria, tuberculosis, and non-communicable diseases, and we work on holding all leaders accountable, such as business, civil society, funding partners and bi and multi-lateral development organizations.

Stronger leadership is required in order to ensure that universal health rights and services are provided that are accessible, affordable, acceptable and quality in nature. This also requires impact mitigation programmes to the people who need them, and rights and services that are catered to the needs of those who are most marginalized by society, policy or otherwise.

AAI uses research to develop various tools for stakeholders for them to use in their campaigns to advocate for better health. We conduct only needs-driven, evidence-based research and advocacy that measures performance against the commitments that have been made by governments. We also conduct our own advocacy, capacity building and monitoring and evaluation interventions to encourage those who are delivering on their commitments, identify and put pressure on those who are under-performing and stimulate constructive debate about what can be learned from different approaches and how best practices should be shared. AAI focuses on inclusion of the most marginalized in much of our work and has global reach with an African focus.

Ishtar MSM first came in the forefront in 1997 where they staged the play Cleopatra at the Kenya National theatre. This was an entry point into the lives of homosexuals in Nairobi and developed an atmosphere of trust and openness where great discussion and reflection took place; a topic by Brother Daino discussed in particular is "How can the church respond to pastoral needs of Homosexual community in Nairobi.

Ishtar MSM was registered as a Community Based Organisation in 1999. Whereas Ishtar's initial membership was Male Commercial sex workers, the organization has since developed to be deal with MSM holistically where all MSM and Transgender women (Male to Female) are included.

Our vision is to attain full sexual health rights and social wellbeing for men who have sex with men in Kenya. Its mission is to advance the sexual health rights of MSM and reduce stigma and discrimination aliened with them by creating general awareness with the aim of empowering the MSM community and the society at large, advocating for the rights to good health, access to STI/HIV and AIDS related prevention, care and treatment in Kenya.

THE MSM HEALTH ADVOCACY PROJECT

On a global level, men who have sex with men or MSM are 19 times more likely to be infected by HIV than people in the “general population”. Several key studies have shown that MSM in Africa are about 19% more susceptible to acquiring HIV than the general population.

Although both of these 19s mean different things, both show alarming disregard for the health needs of MSM in Africa. Despite the grave need for urgent attention to their health needs, they remain at the margins of HIV interventions. This is evidenced by the lack of service provision to meet the specific health needs of MSM as well as the lack of comprehensive data analyzing the HIV epidemiology occurring amongst MSM, and this exclusion occurs in all regions of the continent.

The MSM Health Advocacy Project (MHAP) is run by AMSHeR and aims at improving the policy and health environment for the delivery of HIV services to MSM at all levels. The objectives of the project are: establish a baseline of current MSM health services in Cote D’Ivoire, Kenya and Nigeria; increase capacity to collect data, analyze, and report on MSM health disparities by AMSHeR member organizations in those countries; develop an advocacy program for improvements in health outcomes; build a community network for health advocacy between the three countries. The MHAP is a three years project and will utilize an MSM Health Scorecard as the tool for establishing a baseline and building accountability for MSM health services.

THE MSM HEALTH SCORECARD

The MSM Health Scorecard is a tool developed by AMSHeR, with the technical support of AIDS Accountability International; the tool includes relevant country level indicators that help monitor accountability of governments, civil society organizations or funding partners in improving the health of MSM.

Scorecard Elements

The MSM Health Scorecard contains sixteen elements each of which evaluates a different aspect of the response to MSM by different stakeholders: government, civil society and funding partners.

PART I: Holding Government Accountable
Element 1: HIV Prevalence
Element 2: Sexually Transmitted Infections
Element 3: HIV Prevention
Element 4: HIV Testing
Element 5: Condom Use
Element 6: Reproductive Health Commodities
Element 7: Policy Environment
Element 8: Legal Environment
Element 9: Sensitization and Training of Healthcare Workers
Element 10: Budget and Financing
Element 11: Service ProvisionBudget and Financing
PART II: Holding Civil Society Accountable
Element 12: Civil Society Organizations
Element 13: Civil Society Organizations Advocacy
Element 14: Civil Society OrganizationsOutreach
PART III: Holding Funding Partners Accountable
Element 15: Funding for MSM Organizations
Element 16: Funders' Policy on Gender and Sexual Orientation
PART IV: Lessons Learned

AAI Scorecard Grades

AAI places countries in five broad 'grades', from A to E. The grade is based on the percentage reported by the country according to the following formula: A (81-100%); B (61-80%); C (41-60%); D (21-40%); E (0-20%) – from A (very good) to E (very poor). If a country has not reported on a particular element then the score will be marked as ND for No Data and because the value of knowing what the circumstance of your epidemic is paramount to informing and constructing your response, these indicators are given a numerical value of 0.

Score	Grade
81-100 %	A
61-80 %	B
41-60%	C
21-40%	D
0-20 %	E
No data submitted =0%	ND

Sometimes the lower the percentage, the better the health response is. This kind of situation happens for example when we examine HIV prevalence. We want lower percentages. In these circumstances in this scorecard, the grade has been based on that used by AMfAR in the MSM, HIV, and the Road to Universal Access – How Far Have We Come? Report. This roots and connects this work so that it can be compared with this global analysis report, and is AAI's own logical conclusion based on our own analysis.

Score	Grade
0-5 %	A
6-10 %	B
11-15%	C
16-20%	D
>20 %	E
No data submitted = 0%	ND

In order to calculate these grades one of two methods has been used in this scorecard.

Developing the MSM Health Scorecard

Methodology

An Implementation Guide was developed by AMSHeR and AAI to help understand the rationale behind each indicator, as well as what each indicator measures and the data limitations. A questionnaire was concomitantly conceived to facilitate in-country quality data collection. Workshops on how to complete the questionnaire were run by AMSHeR and the data then submitted to AAI. AAI used the data collected to analyze and produce country Scorecards and Reports.

Methodology and data limitations

An Implementation Guide was developed by AMSHeR and AAI to help understand the rationale behind each indicator, as well as what each indicator measures and the data limitations. A questionnaire was concomitantly conceived to facilitate in-country quality data collection. Workshops on how to complete the questionnaire were run by AMSHeR and the data then submitted to AAI. AAI used the data collected to analyze and produce country Scorecards and Reports. This is available online at www.aidsaccountability.org.

Lessons learnt

The main challenges in the development of MSM Scorecard Guidelines and Questionnaire were the lack of available official data on indicators for MSM health in Africa and the disparity of data sources for same indicators in different countries. AMSHeR mapping and baseline reporting projects will have to provide many indicators through primary data collection.

It is important for coordinating organisations working on MSM health to consolidate all the data available to inform programming. This data should be consolidated and made available to relevant people to inform programming. Ishtar has worked for years and kept all data it's only recently that Ishtar has stated using the new NASCOP tools and data is shared in a national level.

It is also important for us have a national coordination body that will feed all the information gathered to the National policy level. Ishtar in its capacity and the representative MSM at the national steering committees needs to form a reporting mechanism to capture the information and move it forward.

Mainstream organisations should be held accountable when receiving funding for MSM programming. MSM led organisations capacity should be built to be able to run programs on their own.

Using the MSM Health Scorecard

Objective

The Scorecards will be used by AMSHeR and member organizations for advocacy and tracking of progress on strategic indicators of MSM health. The reports will summarize the analysis of the data, detailing key assumptions, identifying challenges and successes to data analysis, and providing recommendations for improvements for future versions.

Next steps

Training will be provided at a later stage in health policy advocacy, combined with support to develop and execute a national health policy advocacy strategy targeted to engagement with Ministries of Health, national AIDS councils, Country Coordinating Mechanisms, PEPFAR and their programme implementers, and advocacy bodies on behalf of MSM.

Introduction to the human rights situation of MSM in Kenya	
What is happening in Kenya right now?	Homosexuality is criminalised in Kenya with up to 14 years in jail. The laws criminalising homosexuality fall under the "offenses against morality" Section 63 of the Kenyan Penal Code. These laws are also referred to as "unnatural offenses" or "carnal knowledge against the order of nature", with punishment ranging from 5-14 years in jail. Mombasa is the only council in Kenya that has provisions in its by-laws that directly target homosexuality. The atmosphere in major towns appears more tolerant which has allowed the (GALCK), the umbrella LGBT organisation in Kenya to facilitate community organising.

What is the climate regarding gay rights now?	The social context in Kenya remains overwhelmingly homophobic and trans phobic. Sporadic reports of violent and brutal evictions of suspected LGBTI's have been reported. The LGBTI community in Kenya have therefore remained on the margins of mainstream civil society engagement or others have gone into seclusion and underground out of fear of persecution and arrest for being gay. It should also be noted that organisations that conduct health programming around HIV&AIDS and SRHR have made more inroads than those whose primary focus is human rights and advocacy.
What was the climate for gay rights in the past?	The recognition or championing of gay rights had not been on the national agenda in Kenya before. LGBTI persons living with HIV have faced criminalisation with potential jail terms of up to seven years. The East African Bill has yet to be domesticated in each of the east African countries including Kenya. The LGBTI community is generally of the view that it is unlikely the law would be applied in practice.
What do you hope will happen in the next year or two?	It is hoped that the Draft Key Populations Policy will be approved and adopted. In the case where the policy may not be adopted the LGBTI community could continue to face undermining of their fundamental human rights and attacks on their privacy and human dignity.
What do you think will happen in the next ten years for gay rights in Nigeria?	Civil society will organise, advocate for, and give effect to the inclusive principles prescribed in the Kenya Bill of Rights. The LGBTI community will actively work toward the inclusion of the protection of sexual orientation in the Constitution.
What are your biggest challenges?	• Policies that are in draft form with no clear plans of them being adopted. • Access to SRHR services e.g. availability of condoms/lubrication. • Stigma and discrimination. • Poor knowledge of the judiciary and healthcare providers about human sexuality and human rights. • Penal codes that discriminate and criminalise LGBTI persons. • Lack of political will to promote and protect the rights of LGBTI persons.
What do you need others to do to help?	Support in strengthening partnerships and alliances with other civil society and human rights organisations will assist in building the LGBTI movement in Kenya. Lobbying government, lawmakers and religious leaders to recognise the rights of LGBTI's. Sensitisation and creating awareness among religious, political leaders and the judiciary. SRHR training modules that is aimed at empowering activists. Governance and Institutional capacity strengthening that assists organisations working for the advancement of LGBTI rights. Continued assistance in gathering primary data and strengthening policy advocacy. The Kenya LGBTI community have a favourable bias toward working on multi tier approaches toward programme interventions that includes health, human rights and law and policy.
What must others NOT do, so that the situation for gay people gets better?	The greatest risk is when other actors intervene on behalf of the community. Engagement and consultation is key to successful interventions that do not worsen the hostility between government and the community. Gay marriage is an example of an issue that is advocated by some from the global LGBTI lobby that cannot be adopted by the Kenya LGBTI community. The community should not be excluded from planning stages of policy development.
Who are your biggest and most influential allies? Why?	The LGBTI movement in Kenya does not have widespread support from mainstream civil society organisations but strategic alliances and relationships have been forged with the NACC and the National AIDS STI Control Programme. They have assisted in developing M & E tools and a draft national guideline on key populations. These allies have also assisted in development and adoption of a national MSM peer education curriculum and lubricant provision through NASCOP.
Who are your biggest and most influential enemies? Why?	Religious and political leaders have a huge sphere of influence in Kenya. Those politicians who support the rights of LGBTI's cannot declare this openly. Some mainstream human rights organisations do not consider the rights of LGBTI persons as fundamental human rights. When leaders make public statements about the arrest and banishment of gays incidents of violence usually follow, as people feel justified to act out their prejudice.
Any other thoughts?	

Overall Scorecard

PART I: Holding Government Accountable	**Overall Score: D**
Element 1: HIV Prevalence	Overall Score: C
Element 2: Sexually Transmitted Infections	Overall Score: A
Element 3: HIV Prevention	Overall Score: ND
Element 4: HIV Testing	Overall Score: E
Element 5: Condom Use	Overall Score: ND
Element 6: Reproductive Health Commodities	Overall Score: D
Element 7: Policy Environment	Overall Score: A
Element 8: Legal Environment	Overall Score: D
Element 9: Sensitization and Training of Healthcare Workers	Overall Score: A
Element 10: Budget and Financing	Overall Score: ND
Element 11: Service ProvisionBudget and Financing	Overall Score: ND
PART II: Holding Civil Society Accountable	**Overall Score: E**
Element 12: Civil Society Organizations	Overall Score: ND
Element 13: Civil Society Organizations Advocacy	Overall Score: D
Element 14: Civil Society Organizations Outreach	Overall Score: ND
PART III: Holding Funding Partners Accountable	**Overall Score: B**
Element 15: Funding for MSM Organizations	Overall Score: ND
Element 16: Funders' Policy on Gender and Sexual Orientation	Overall Score: A

PART I: Holding Government Accountable		Overall Score: D
Element 1: HIV Prevalence		**Overall Score: C**
Indicator name	Indicator %	Source
Indicator 1a HIV prevalence among men who have sex with men (%)	**15.2%**	**The Kenya AIDS Epidemic Update 2012** **Kenya AIDS Strategic Plan 2009/10-2012/2013** **Kenya AIDS indicator survey**
Notes: This figure lumps men who have sex with men (MSM) and prison populations. However it has been noted that institutionalized discrimination and stigmatizing attitudes contribute to the disproportionate risk and vulnerability experienced by sex workers, men who have sex with men, and people who inject drugs. These three populations are estimated to have HIV prevalence of 29.3%, 18.2%, and 60.4%, respectively. he risk of infection increases with age, with HIV prevalence among MSM age 25 and over roughly double that reported among MSM under age 25 (24.5% vs. 12.2%). Prevalence rate for men is 4.4% (Kenya AIDS indicator survey). There is still not much information on HIV/AIDS amongst MSM		
Challenges: 1. Insufficient funding to grassroots organisation such as Ishtar-MSM to carry out clear indicator survey to inform policy. 2. Stigma and discrimination of Key population 3. Punitive laws. 4. Lack of coordination among programs offering services to the MSM population 5. The coming out process for MSM 6. Insufficient SRHR information for MSM 7. Low HIV care and treatment uptake among Gay/MSM		
Recommendations/way forward: 1. Continuous engagement of CSO's to ensure commitment of governments in the fight of HIV/AIDS devoid of any form of stigma and discrimination. 2. As noted in the KNASP Criminalisation of MSM and other key populations impedes access to services, there is need for a multi tier approach to ensure that law and policies are changed/amended. 3. Sufficient funding to ensure organisations are able to carry out programs that can best inform policy and governments on key areas of intervention. 4. Develop a clear well articulated health Advocacy strategy. 5. Avoid duplication of services and encourage partnerships and networking. 6. Invest in research to inform programming. 7. Upscale existing centres to become comprehensive so to encourage adherence and uptake.		
Element 2: Sexually Transmitted Infections		**Overall Score: A**
Indicator name	Indicator %	Source
Indicator 2a Percentage of men who have sex with men who report having an STI in the past 12 months	**0.7%**	**The Kenya AIDS Epidemic Update 2012** **Revitalizing the National STI/ RTI Control Activities in Kenya**
Notes: This number in for Nairobi. There seems to be no comprehensive reporting on STI infections. Most of our programming has been geared toward HIV/AIDS and not STI screening. Currently the adopted NASCOP M&E tools have started capturing STI data to improve evidence based programming.		

Challenges: Many MSM delaying seeking treatment for an STI due to fears of embarrassment or stigmatization (Sharma et al., 2008).

Recommendations/way forward: We need to emphasize and create awareness on STI screening and treatment. Have more focus on creating awareness to our members.

Element 3: HIV Prevention		**Overall Score: ND**
Indicator name	Indicator %	Source
Indicator 3a Percentage of men who have sex with men reached with HIV prevention programmes	**No Specific DATA**	**The Kenya AIDS Epidemic Update 2012**

Notes: The Kenyan data is not disaggregated on the basis of gender and sexual minorities.

Challenges:
1. Lack of specific data targeting MSM.
2. Double stigma associated to sexuality and HIV positive status.
3. Lack of targeted information education and communication geared towards the MSM population.

Recommendations/way forward:
1. Awareness creation and campaigns to encourage testing.
2. Generate specific data targeting MSM.
3. Adequate funding for MSM programming.
4. Promote sex education in schools.

Element 4: HIV Testing		**Overall Score: E**
Indicator name	Indicator %	Source
Indicator 4a Percentage of men who have sex with men that have received an HIV test in their lifetime	**35.5%**	**The Kenya AIDS Epidemic Update 2012**
Indicator 4b Percentage of men who have sex with men that have received an HIV test in the last 12 months and who know their results	**Not available since there is no specific data on this**	

Notes: There is no specific data on the number of MSM who have been through HIV testing and counselling; current data collection tools and report mechanisms have improved and programs are reporting on specific target populations to NASCOP.

Challenges:
1. Insufficient funding to grassroots organisation such as Ishtar-MSM to carry out clear indicator survey to inform policy.
2. Stigma and discrimination of Key population.
3. Punitive laws.

Challenges(continued):
4. Lack of coordination among programs offering services to the MSM population.
5. The coming out process for MSM.
6. Insufficient SRHR information for MSM.
7. Low HIV care and treatment uptake among Gay/MSMitive laws.

Recommendations/way forward:

1. Continuous engagement of CSO's to ensure commitment of governments in the fight of HIV/AIDS devoid of any form of stigma and discrimination.
2. As noted in the KNASP Criminalisation of MSM and other key populations impedes access to services, there is need for a multi tier approach to ensure that law and policies are changed/amended.
3. Sufficient funding to ensure organisations are able to carry out programs that can best inform policy and governments on key areas of intervention.
4. Develop a clear well articulated health Advocacy strategy.
5. Avoid duplication of services and encourage partnerships and networking.
6. Invest in research to inform programming.
7. Upscale existing centres to become comprehensive so to encourage adherence and uptake.

Element 5: Condom Use		**Overall Score: ND**
Indicator name	Indicator %	Source
Indicator 5a Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	**No DATA**	

Notes: Programs have their own data on condoms and lube use, however, this data has not been consolidated to project the national uptake.

Challenges:

1. No funds for the M&E department in budgets
2. Insufficient IEC material targeting the MSM population

Recommendations/way forward:

1. Capacity building for M&E staff.
2. Help organisations with the data they have.
3. increase trainings for MSM on DATA management.
4. Increase funding to hire DATA personnel for MSM.
5. Identify and adopt new IEC material targeting the MSM population.

Element 6: Reproductive Health Commodities				**Overall Score: D**
Indicator name	Indicator %			Source
Indicator 6a Men who have sex with men reporting ever using lubricant during anal sex with man	**No DATA**			
Indicator name	Yes	In Progress	No	Source
Indicator 6b Lubricant on the list of essential drugs		**x**		Kenya AIDS strategic framework 2014. Draft key population policy.

Indicator 6c Mechanisms of procurement for lubricant in place.	**x**			NASCOP and MSM programs
Notes: MS programs share their data with NASCOP and this is accessible.				
Challenges: The government through NACC and NASCOP play safe and does not want to be seen as promoting "gay rights".				
Recommendations/way forward: 1. Increased advocacy. 2. Increased Funding to MSM organisations to procure lubricants. 3. Variety of commodities should be made available**.**				
Element 7: Policy Environment				**Overall Score: A**
Indicator name	YES	No		Source
Indicator 7a Are there policy provisions for men who have sex with men in National Development Plan?	**x**			**KNASP** **Key population guidelines 2014**
If men who have sex with men are mentioned, please provide more details (What is the policy? Is the policy discriminatory or supportive?): They are supportive.				
Indicator 7b Are there policy provisions for men who have sex with men in Common country assessment / UN Development assistance framework?	**x**			**The Kenya AIDS Epidemic Update 2012** **The WHO guidelines** **Kenya AIDS Strategic Plan 2009/10-2012/2013**
If men who have sex with men are mentioned, please provide more details (What is the policy? Is the policy discriminatory or supportive?):				
Indicator 7c Are there policy provisions for men who have sex with men in National HIV Communication Plan?	**x**			**Draft MARPS Policy**
If men who have sex with men are mentioned, please provide more details (What is the policy? Is the policy discriminatory or supportive?): The policy is to address the access to services for Most at risk populations and give recommendations to stakeholders and it is progressive.				
Indicator 7d Are there policy provisions for men who have sex with men in National STI Policy/policy guidelines?	**x**			**National STI Management Policy**
If men who have sex with men are mentioned, please provide more details (What is the policy? Is the policy discriminatory or supportive?): The MARPS policy document.				

Indicator 7e Are there policy provisions for men who have sex with men in National Sexual and Reproductive Health and Rights policy or policy guidelines?	**x**		**The Kenya AIDS Epidemic Update 2012** **Kenya AIDS Strategic Plan 2009/10-2012/2013**
If men who have sex with men are mentioned, please provide more details (What is the policy? Is the policy discriminatory or supportive?): They are supportive.			
Indicator 7f Are there policy provisions for men who have sex with men in National HIV/AIDS Strategic Plans?	**x**		**The Kenya AIDS Epidemic Update 2012** **Kenya AIDS Strategic Plan 2009/10-2012/2013**
If men who have sex with men are mentioned, please provide more details (What is the policy? Is the policy discriminatory or supportive?): They are supportive.			
Indicator 7g Are there policy provisions for men who have sex with men in National Health Policy?	**x**		
If men who have sex with men are mentioned, please provide more details (What is the policy? Is the policy discriminatory or supportive?): They are supportive.			
Indicator 7h Are there policy provisions for men who have sex with men in National Composite Policy Index (NCPI)?	**x**		
If men who have sex with men are mentioned, please provide more details (What is the policy? Is the policy discriminatory or supportive?): They are supportive.			

Indicator 7i Are there policy provisions for men who have sex with men in National Health Policy?	**x**		
If men who have sex with men are mentioned, please provide more details (What is the policy? Is the policy discriminatory or supportive?): They are supportive.			
Notes: There is need to further verify the information in the policy documents.			
Recommendations/way forward: There is a need to update and further review the policy documents available.			
Element 8: Legal Environment			**Overall Score: D**
Indicator name	YES	No	Source
Indicator 8a Are homosexual acts legal?		**x**	**Kenya Penal Code**
Indicator 8b Death penalty is not used as punishment for homosexual acts?		**x**	**Kenya Penal Code**
Indicator 8c Is there equal age of consent for homosexual and heterosexual acts?		**x**	**Kenya Penal Code** **Kenya Constitution**
Indicator 8d Is there prohibition of discrimination in employment based on sexual orientation?	**x**		**Kenya Constitution**
Indicator 8e Is there constitutional prohibition of discrimination based on sexual orientation?	**x**		
Indicator 8f Is marriage legal for same-sex couples?		**x**	**Kenya Constitution**
Indicator 8g Is joint adoption by same-sex couples legal?		**x**	**Kenya Penal Code** **Kenya Constitution**
Notes: The constitution describes marriage as man and woman, however being gay is not illegal in Kenya but the act of sexual intercourse between men is illegal when caught and proven.			
Challenges: These laws provide grounds for stigma, discrimination, violence and exclusion.			
Recommendations/way forward: Involve in the multi-tier approach with GALCK.			
Element 9: Sensitization and Training of Healthcare Workers			**Overall Score: A**
Indicator name	YES	No	Source

Indicator 9a Inclusion of MSM sensitization and/or specific health needs for prevention, diagnosis and treatment in training manuals for health care workers**.**	**x**		**Liverpool VCT health provider manual.**
Notes: MSM organisations have taken lead in producing manuals that are adopted by government bodies that work with Key population e.g. TWG (Technical working group).			
Challenges: These processes are long and tedious and take too long to be adopted.			
Recommendations/way forward: A speedy process to adopt and implement existing manuals.			
Element 10: Budget and financing			**Overall Score: ND**
Indicator name	Indicator %		Source
Indicator 10a Percentage of government budget allocation for health activities which focus on men who have sex with men	**No DATA**		
Notes: Few organisations have been able to access government funds through NACC under the TOWA (Total war against AIDS) program.			
Challenges: Due to criminalisation of MSM we still have not been able to get direct government support for fear by the system to look like they are supporting MSMs.			
Recommendations/way forward: 1. Increased advocacy by grass root organising 2. Holding government and stakeholders accountable			
Element 11: Service ProvisionBudget and Financing			**Overall Score: ND**
Indicator name	Indicator %		Source

Indicator 11a Number of public clinics providing services to men who have sex with men.	**No DATA**	

Notes: It has not been easy for MSM to access services openly at the public clinics.

Challenges:
1. Stigma and discrimination associated with being gay.
2. The medical ethical processes of supporting MSM which is still considered illegal in Kenya.

Recommendations/way forward:
1. Mapping of clinics offering services to MSM.
2. Increase of advocacy, awareness creation and sensitization to health providers.
3. Increase of funding to MSM led organisations to provide services e.g. the SASA centre clinic.

PART II: Holding Civil Society Accountable			**Overall Score: E**
Element 12: Civil Society Organizations			**Overall Score: ND**
Indicator name	Indicate # (Legally Registered)	Indicate # (Not Registered)	Source
Indicator 12a Number of MSM civil society organizations in the country	**NO DATA**	**NO DATA**	**GALCK and NASCOP**

Notes:
This data is available but we couldn't access it during this report.
Some of this data is not shared in public platforms due to security reasons.

Challenges:
1. Punitive laws in Kenya section 162 to 165 in Penal code especially around registration.
2. Social Discrimination and stigma.

Recommendations/way forward:
1. A lot of advocacy required.
2. Challenging these laws.

Element 13: Civil Society Organizations Advocacy		**Overall Score: D**
Indicator name	Indicator #	Source

Indicator 13a Number of CSO members of the National Human Rights Network that support Sexual Orientation and Gender Identity as a human rights issue.	**2**	**Kenya national commission of human rights.** **Kenya human rights commission.**
Are there other non-MSM organizations in your country who support MSM health and rights in their work? Please provide more details: Yes, (See attached matrix).		
Notes: Some of the main stream organisations receive funding for MSM programming but do not work with these populations.		
Challenges: Registration of MSM groups making receiving of funds difficult. Some donors don't think MSM led organisations have capacity to handle funds and implement programs.		
Recommendations/way forward: Build the capacity of MSM led organisations to handle funds and programs. Direct funding to MSM organisations.		

Element 14: Civil Society Organizations Outreach		**Overall Score: ND**
Indicator name	Indicator #	Source
Indicator 14a Number of civil society organizations, clinics and service delivery points that provide healthcare services to men who have sex with men.	**NO DATA**	**NO DATA**
Notes: This data is available but we couldn't access it during this report. Some of this data is not shared in public platforms due to security reasons.		
Challenges: 1. Punitive laws in Kenya section 162 to 165 in Penal code especially around registration. 2. Social Discrimination and stigma.		
Recommendations/way forward: 1. A lot of advocacy required. 2. Challenging these laws.		

PART III: Holding Funding Partners Accountable		Overall Score: B
Element 15: Funding for MSM Organizations		**Overall Score: ND**
Indicator name	Indicator #	Source
Indicator 15a Number of MSM organizations that are recipients of funding partners.	**No Data**	**UHAI LGBTI organising.**
Indicator 15b Total estimated amount allocated to MSM CSOs in country over 2010-2013	**No Data**	
Notes: It's difficult to access this information as many organisations/ funders are not willing to publicly share this information.		
Challenges: Without the above data it is difficult to know/ quantify the amount of money MSM organisations are receiving.		
Recommendations/way forward: Funding/donor information should be shared with the relevant parties to ease programming.		

Element 16: Funders' Policy on Gender and Sexual Orientation			Overall Score: A
Indicator name	Yes	No	Source
Indicator 16a Do the top five funders in country (by $ amount) have a strategy that includes men who have sex with men?	**x**		**Ishtar data and networks.**
Notes: Some of these organizations work in funding specific programs.			
Challenges: Some MSM led organisations are not registered therefore unable to receive funds Some donors do not consider SOGIE (sexual orientation gender identity and expression) issues as their area of priority.			
Recommendations/way forward: Sensitization training on SOGI issues.			

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African Men for Sexual Health & Rights [AMSHeR]

+27(0)11 482 9201

27 Clieveden Avenue
Auckland Park
Johannesburg
South Africa
2092

amsher.org

AIDS Accountability International

+27 (0)21 424 2057

102 Greenmarket Place
54 Shortmarket Street
Cape Town
South Africa
8000

aidsaccountability.org