AT RISK

Rights Violations of HIV-Positive Women in Kenyan Health Facilities

CENTER FOR REPRODUCTIVE RIGHTS

FEDERATION OF WOMEN LAWYERS
HAKI ZA AKINA MAMA
FIDA KENYA

The Center for Reproductive Rights

CRR Mission

The Center for Reproductive Rights uses the law to advance reproductive freedom as a fundamental right that all governments are legally obligated to protect, respect, and fulfill.

CRR Vision

Reproductive freedom lies at the heart of the promise of human dignity, self-determination, and equality embodied in both the U.S. Constitution and the Universal Declaration of Human Rights. The Center works toward the time when that promise is enshrined in law in the United States and throughout the world. We envision a world in which all women are free to decide whether and when to have children; where all women have access to the best reproductive healthcare available; where all women can exercise their choices without coercion. More simply put, we envision a world where all women participate with full dignity as equal members of society.

Federation of Women Lawyers—Kenya

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Table of Abbreviations and Glossary

Abbreviation	Complete Term and Definition
2004 KSPAS	2004 Kenya Service Provision Assessment Survey: survey conducted at the behest of the Kenyan Ministry of Health about the state of health care services in Kenya.
African Charter	African Charter on Human and Peoples' Rights: international convention that promotes and protects human rights on the African continent.
African Charter on Children	African Charter on the Rights and Welfare of the Child: regional human rights treaty protecting the rights of children in Africa.
ANC	Antenatal care: medical care for pregnant women.
ART Guidelines	Guidelines for Antiretroviral Drug Therapy in Kenya: guidelines issued by NASCOP for HIV/AIDS antiretroviral treatment programs.
ARV	Antiretroviral: medication that inhibits the replication of HIV.
CCC	Comprehensive Care Centre: health center, usually located at a district hospital, that provides integrated antenatal care and HIV treatment to women.
CDC	Center for Disease Control: an agency of the United States Department of Health and Human Services that seeks to promote public health by controlling and preventing disease.
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women: International treaty codifying states' duties to eliminate discrimination against women.
CEDAW Committee	Committee on the Elimination of Discrimination against Women: UN body charged with monitoring states' implementation of CEDAW.
CESCR	Committee on Economic, Social and Cultural Rights: UN body charged with monitoring states' implementation of the International Covenant on Economic, Social and Cultural Rights.
CHAK	Christian Health Association of Kenya: Protestant faith-based organisation that operates health facilities in Kenya.
Children's Rights Convention	Convention on the Rights of the Child: International treaty upholding the human rights of children.
Civil and Political Rights Covenant	International Covenant on Civil and Political Rights: International treaty protecting individuals' civil and political human rights.
Convention against Torture	Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment: International treaty aimed at preventing torture worldwide.
CRR	Center for Reproductive Rights: a nonprofit, legal advocacy organisation that promotes and defends the reproductive rights of women worldwide.
DTC	Diagnostic Testing and Counselling: testing and counselling services that are part of a diagnostic work-up to determine whether a patient displaying symptoms that could be attributable to HIV has the virus.

Economic, Social and Cultural Rights Covenant	International Covenant on Economic, Social and Cultural Rights: International treaty protecting individuals' economic, social, and cultural human rights.
ESCR Committee	See CESCR.
FACES	Family AIDS Care and Educational Services: a HIV/AIDS treatment and care program in Kenya.
FIDA Kenya	Federation of Women Lawyers—Kenya: NGO that aims to improve the legal standing of women in Kenya.
HIV Act	HIV and AIDS Prevention and Control Act: act receiving presidential assent on December 30, 2006 and gazetted on January 2, 2007, which codifies the measures for treatment, counselling, support and care of HIV/AIDS infected and at risk patients.
HRC	Human Rights Committee: UN body responsible for monitoring the states' implementation of the Civil and Political Rights Covenant.
ICPD	The United Nations International Conference on Population and Development (ICPD) was held in 1994, in Cairo, Egypt. At this conference, world leaders, high-ranking officials, representatives of nongovernmental organisations and UN agencies gathered to agree on a Programme of Action.
ICW	International Community of Women Living with HIV/AIDS: a UK-based charity and international network that aims to promote awareness and to provide support services to HIV-positive women worldwide.
International Guidelines	International Guidelines on HIV/AIDS and Human Rights: 2006 Consolidated Version: guidelines prepared by OHCHR and UNAIDS that address human rights violations experienced by people living with HIV, including discrimination, poverty and violence, and that compile best practice standards.
KELIN	Kenya Ethical and Legal Issues Network on HIV and AIDS: NGO that aims to raise awareness about legal issues related to HIV/AIDS in Kenya.
Kenya Health Workers Survey	2005 Kenya Health Workers Survey: survey conducted at the behest of the Kenyan Ministry of Health that examined the preparedness of the Kenyan health system, including health workers, in regard to HIV/AIDS management.
Maputo Protocol	African Charter's Protocol on the Rights of Women in Africa: Treaty that guarantees a wide range of women's civil and political rights, as well as general economic, social, and cultural rights. The protocol explicitly guarantees the right to health and the reproductive rights of women.
NACC	National AIDS Control Council: Kenyan governmental organisation responsible for providing policy and a strategic framework to coordinate and mobilize resources for the prevention of HIV and for the care and support of HIV/AIDS patients.
NASCOP	National AIDS and STD Control Programme: Kenyan governmental organisation responsible for coordinating, monitoring and implementing guidelines related to VCT, PMTCT, ARVs, blood safety, sexually transmitted diseases, tuberculosis and leprosy.
National Reproductive Health Strategy	Healthcare agenda, issued by the Kenyan Ministry of Health, aimed at creating a comprehensive and integrated system of reproductive healthcare in Kenya that would involve governmental and nongovernmental organisations and the private sector.

NCAPD	National Coordinating Agency for Population and Development: Kenyan governmental organisation responsible for facilitating coordination and management of population concerns in Kenya, and providing information about population and development.
NGO	Nongovernmental organisation.
OHCHR	Office of the UN High Commissioner for Human Rights: UN body that spearheads international efforts to promote and protect human rights.
PEP	Post-exposure prophylaxis: prophylactic treatment, involving a regimen of antiretroviral drugs, following high-risk exposure to the HIV virus.
PEPFAR	President's Emergency Plan for AIDS Relief: The United States' 5-year, $15-billion health initiative dedicated to fighting HIV/AIDS worldwide.
PMTCT	Prevention of Mother-to-Child HIV/AIDS Transmission: strategies to prevent transmission of HIV/AIDS from mother to child during pregnancy, labour and delivery, and breastfeeding.
PMTCT Guidelines	National Guidelines: Prevention of Mother-to-Child HIV/AIDS Transmission: guidelines issued by the Kenyan Ministry of Health delineating the scope and standards of care for women living with HIV to prevent transmission to their children during pregnancy, labour and delivery, and breastfeeding.
TBA	Traditional birth attendant: midwife, often lacking knowledge about HIV transmission, who assists labour and delivery.
UDHR	Universal Declaration of Human Rights: UN human rights instrument at the foundation of modern international human rights law.
UNAIDS	Joint United Nations Programme on HIV/AIDS: UN agency devoted to global action on HIV/AIDS.
UNFPA	United Nations Population Fund: UN agency devoted to funding and supporting population and reproductive health programs in low-income countries.
VCT	Voluntary Counselling and Testing for HIV: HIV/AIDS testing and counselling program, which serves as an entry point for treatment and care of people living with HIV.
VCT Guidelines	National Guidelines for Voluntary Counselling and Testing: guidelines delineating the scope and standards of care for VCT providers, issued by the Kenyan Ministry of Health.
WOFAK	Women Fighting AIDS in Kenya: an organisation that provides support services to HIV-positive Kenyan women.
WHO	World Health Organisation: UN agency devoted to researching and promoting public health worldwide.

Executive Summary

Although the Kenyan government has taken positive steps to address the HIV epidemic in Kenya, and to advance women's reproductive health and rights, much work remains to be done, particularly in protecting the rights of women living with and affected by HIV. Following an earlier report from the Federation of Women Lawyers–Kenya (FIDA Kenya) and the Center for Reproductive Rights (CRR), *Failure to Deliver: Violations of Women's Human Rights in Kenyan Health Facilities*, which focused on women's experiences seeking reproductive health services in the deeply troubled Kenyan health care system, this report examines the specific implications of those systemic weaknesses for women in the context of HIV. While focusing primarily on HIV-positive women's experiences within the context of maternal health care, the findings and their implications highlight the need to strengthen the Kenyan health care system overall and to ensure stringent protections of patients' rights in general, with special attention to the rights of HIV-positive people seeking health care.

Women seeking reproductive health services in Kenya suffer serious human rights violations, including physical and verbal abuse and detention in health facilities for inability to pay. In addition, shortages of funding, medical staff, and equipment plague the health care system and dramatically interfere with the ability of health care staff to provide adequate care. When women living with HIV seek reproductive health care services, the harms of a weak health care system, which does not respect patients' rights, are intensified and multiplied, particularly since women living with HIV/AIDS require specialised counselling and care during their reproductive lives.

The Kenyan government has developed a legislative framework around HIV/AIDS that is in the process of being adopted. The HIV and AIDS Prevention and Control Act [HIV Act], while not yet operational, codifies measures for treatment, counselling, care and support of people living with HIV. Although this act codifies many strong human rights guarantees that are essential to combating the human rights violations women confront in the context of HIV/AIDS and access to reproductive health care and services, it also contains troubling provisions that permit partner disclosure by health care workers and criminalize the transmission of HIV in certain instances.

Women are subject to coercive practices and violations of informed consent and confidentiality in testing for HIV, particularly during pregnancy. Women seeking maternal care report that health care providers often disregard informed consent procedures for HIV testing, in violation of Kenya's National Guidelines for Voluntary Counselling and Testing, and National Guidelines: Prevention of Mother-to-Child HIV/AIDS Transmission. Women report being subjected to HIV testing without their knowledge or consent, or being forced to submit to an HIV test. Moreover, Kenyan government officials express confusion about Kenya's informed consent policy, and suggest that mandatory or compulsory HIV testing is an element of the antenatal treatment offered at Kenyan health care facilities. Testing pregnant women for HIV without their consent can diminish their confidence in the health care system and drive women away from prevention of mother-to-child transmission of HIV (PMTCT) programmes, limiting their effectiveness and reducing participation of those in need of care or at-risk.

Kenyan women also report violations of their rights to confidentiality and privacy in regard to their HIV/AIDS status by health care providers, who disclose such women's sero-status in the presence of other patients and without first disclosing it to such women. Furthermore, women indicate that both pre- and post-test counselling about HIV, as well as PMTCT counselling, is deficient in Kenya. They report that health care professionals do not provide information and counselling about the importance of undergoing an HIV test in preparation for childbirth, or adequate information about the prevention of mother-to-child HIV transmission, once a woman is informed that she is HIV-positive. Furthermore, Kenya's health care providers report that they require additional training in the provision of HIV and PMTCT counselling. Inadequate counselling places the lives and health of Kenyan women at risk because patients who do not receive adequate information about their sero-status, HIV and PMTCT may forego treatment for this illness.

In some cases, anti-retroviral (ARV) treatment is simply not available, although provision of ARVs to women is essential in combating HIV/AIDS because it can reduce the mortality of women, improves their health, and increases the risk of survival of their offspring and the prevention of HIV transmission. Providing adequate access to HIV treatment is a significant struggle for many health care facilities because of challenges in distribution, infrastructure, administration, staffing, and reliable supply of ARVs. Women encounter a number of barriers when trying to access treatment, such as negative attitudes of health care providers, long waits at health care facilities, expensive transport, unanticipated fees associated with free HIV treatment, and lack of medicine. One woman described being turned away from counselling sessions and denied medication. Additionally, many service providers who operate existing centres are not adequately trained in the appropriate methods of administering ARV treatment.

The report also documents some of the structural barriers that interfere with the provision of quality care by health care providers. Women report that health care providers do not take all appropriate measures to reduce the risk of transmission of HIV to children, such as immediately cleaning the baby once the mother has delivered. Furthermore, many facilities lack the equipment, supplies, and infrastructure necessary to create a hygienic delivery environment, such as a water source, antiseptics and gloves. As a result of the limited resources and facilities at many hospitals, women report being forced to share beds and supplies with other women in overcrowded maternity wards. The lack of adequate health care supplies and infrastructure, coupled with chronic understaffing, creates unhygienic conditions that pose dramatic threats to the lives and health of mothers and their babies and may expose women who are not HIV-positive to the possibility of contracting the virus. One woman attributes her contraction of HIV to the fact that she was cut during her delivery by a pair of unsterilised scissors immediately after they were used to cut another patient.

Furthermore, the lack of the materials and supplies required for the administration of proper medical treatment compromises the ability of health care providers to take universal precautions, such as the use of post-exposure prophylaxis, to protect themselves and others against the transmission of HIV, which can result in the refusal of health care professionals to provide medical treatment to HIV-positive patients.

Women in general often experience mistreatment and harassment in seeking delivery services in Kenyan health facilities. This abuse is exacerbated for women who are HIV positive. Women living with HIV/AIDS confront biases and negative attitudes from health care providers, particularly regarding their sexual and reproductive health practices, although discrimination against persons living with HIV

is prohibited by law. Women living with HIV are frequently turned away from public-health facilities or secluded in an area of the hospital away from other patients, and referred to private hospitals specializing in HIV care, where costs are usually higher. Additionally, these women are reprimanded for bearing children or being sexually active, and denied access to contraception, family planning and maternity services. This discrimination that HIV-positive women experience may increase their risks of transmitting the virus to their partners and children, or unintentionally conceiving.

HIV-positive women also confront cultural stigma regarding their HIV status, and risk domestic violence and abandonment by their partners, leaving them financially vulnerable. Women report that even the act of taking an HIV test may subject them to domestic abuse from their partners. Such exposure to domestic violence and fear of abandonment present tremendous obstacles to many women, who may forego HIV treatment and care services in order to refrain from drawing attention to their illness and confronting a situation in which they must reveal their sero-status to their partners.

These types of violations have serious ramifications for the government's efforts to address the HIV epidemic in Kenya. Negative health care experiences can discourage HIV-positive women from seeking medical care or lead them to seek care from informal sources, such as traditional birth attendants who are frequently even less equipped to attend to the reproductive health needs of HIV-positive women. Additionally, lack of appropriate care and information from providers around PMTCT can increase the risk of transmission to children.

The abuse, negligence and denial documented in this report have more than just public health implications; they also constitute serious violations of human rights that are protected under national, regional, and international law. Fundamental human rights that the government of Kenya is obligated to guarantee include the right to health; the right to privacy and informed consent; the right to be free from torture and cruel, inhuman or degrading treatment; the right to life, liberty and security of person; the right to dignity; the right to found a family; the rights to non-discrimination, equal protection, and equality before the law; and the right to information. The violations described in this report demonstrate that Kenya is not honouring its domestic and global commitments to respect, protect, and fulfil these rights.

FIDA Kenya/CRR urge the Kenyan government to back its stated commitment to combat HIV/AIDS and ensure women's reproductive health and health care reform with the necessary actions. Until the government corrects the problems outlined in this report and restores public confidence in the health care system and HIV/AIDS treatment and care programmes, the public's negative views of the system will be one more barrier to improving the care and overall health of the people of Kenya.

One key step is addressing the problems with the HIV and AIDS Prevention and Control Act. The Kenyan government should remove the provisions of the act that violate human rights by permitting partner disclosure by health care workers and criminalising transmission of HIV, while operationalizing the strong human rights guarantees contained in the act. Additionally, conducting a public awareness campaign about the act, and the guidelines promulgated by the Ministry of Health, which are relevant to care, treatment and prevention of HIV/AIDS, as well as providing training to health care providers on the provisions of the HIV Act and relevant guidelines, will ensure that health care providers understand and can observe appropriate procedures around issues of informed consent, confidentiality, stigma, discrimination and professional standards of care. Adherence to these procedures will bolster the confidence of women in the Kenyan health care system, and encourage its use.

This supplement is based on research and interviews conducted by FIDA Kenya/CRR between November 2006 and December 2007. For *Failure to Deliver*, FIDA Kenya/CRR gathered more than 120 women's experiences through a combination of in-depth interviews, focus group discussions, and questionnaires. FIDA Kenya/CRR also conducted site visits to private and public facilities and spoke to health care providers and administrators, leaders of medical associations, and officials at licensing and regulatory bodies, and reviewed government guidelines, standards, and manuals on issues pertaining to reproductive health services and media coverage of reproductive health issues for the past 10 years. The interviews and site visits that were conducted for *Failure to Deliver* were supplemented by interviews with the National Coordinating Agency for Population and Development (NCAPD), the National AIDS Control Council (NACC), the National AIDS/STD, TB and Leprosy Control Programme (NASCOP), and NGOs working on HIV. Additionally, FIDA Kenya/CRR reviewed government guidelines, standards, and manuals on issues pertaining to HIV/AIDS. Data from the 2003 Kenya Demographic Health Survey, the 2004 Kenya Service Provision Assessment Survey, and the 2005 Kenya Health Workers Survey has been used both to provide a national perspective on reproductive health and HIV/AIDS and to corroborate specific rights violations. Two additional focus groups with a total of 36 HIV-positive women, which were organised by the Victory Post Test Group under the umbrella of Liverpool VCT, were held in Kisumu. To protect their confidentiality, women's real names are not used in either report. For the same reason, certain identifying information has been withheld for other interviewees where necessary.

Introduction

Although the Kenyan government has taken positive steps to address the nation's HIV epidemic, much work remains to be done, particularly in protecting the rights of women living with and affected by HIV. An earlier report discussed women's experiences with reproductive health services in the deeply troubled Kenyan health care system; this report examines the specific implications of those systemic weaknesses for women in the context of HIV. While focusing primarily on the experiences of HIV-positive women within the context of maternal health care, this report's findings and their implications highlight the need to strengthen the entire health care system and to ensure stringent protections of all patients' rights, with special attention to the rights of those living with HIV.

HIV AND WOMEN IN KENYA

- In 1999, the Kenyan government declared the HIV/AIDS epidemic a national crisis and identified it as "the single most important health challenge that Kenya has faced in its post-independence history."[1]
- The AIDS epidemic particularly affects the women of Kenya, among whom the prevalence rate of HIV is nearly twice that of men, according to the 2006 HIV Sentinel survey.[2]
- The HIV prevalence rate in Kenya among women aged 20-24 is significantly higher than that of men in the same age group (9% and 2%, respectively).[3]
- Using 2006 data, the Kenyan National AIDS Control Council (NACC) estimates that "1.5 million pregnant women need counselling and testing each year to determine their HIV sero-status,"[4] while "68,000 women need treatment to prevent Mother-to-Child-Transmission of HIV."[5]

Objectives of this Report

Failure to Deliver: Violations of Women's Human Rights in Kenyan Health Facilities, which was released by the Federation of Women Lawyers—Kenya (FIDA Kenya) and the Center for Reproductive Rights (CRR) in July 2007, revealed the widespread and longstanding systemic problems that impair the delivery of quality reproductive health care. While the Kenyan government has taken many positive steps to advance women's reproductive health and rights, women seeking reproductive health services in Kenya continue to face serious human rights violations, including physical and verbal abuse and detention in health facilities for inability to pay fees. Shortages of funding, medical staff, and equipment plague the health care system, particularly in the public sector, and dramatically interfere with the ability of health care workers to provide adequate care.[6]

In the course of researching *Failure to Deliver*, it became clear that the report's findings have specific implications in the context of HIV. When women living with HIV seek reproductive care, the dangers of a weak health-care system that does not respect patients' rights can be intensified and multiplied, particularly since women living with HIV/AIDS "require additional care and counselling during their reproductive li[ves]."[7] In addition, when HIV-related stigma and discrimination intersect with gender

inequalities, their impact is exacerbated. As statistics indicate, the HIV epidemic in Kenya, as in other countries, "is increasingly . . . a strongly gendered health, development and human rights issue."[8] According to one Kenyan health care provider, HIV is a disease with a feminine face.[9] This report, drawing on the findings of the original report as well as additional research and interviews, highlights some of these implications for women living with or affected by HIV and the rights violations that these women encounter.

Women confront a range of human rights violations in the context of HIV/AIDS and access to reproductive health care. For some, services such as those necessary for the prevention of mother-to-child transmission (PMTCT) or anti-retroviral treatment are simply not available. In other instances, women are subject to coercive practices and violations of informed consent and confidentiality in testing for HIV during pregnancy or delivery. Women described being turned away from public hospitals and directed to private facilities specializing in HIV care, encountering extensive delays in receiving essential and particularized treatment, and being forced to pay unclear and unexplained costs for services. Health care workers may deny women information on critical treatment options, such as the available methods to reduce perinatal transmission of the virus. Moreover, women living with HIV often encounter discrimination at the hands of health-care personnel, many of whom hold negative views of HIV-positive women's sexual activity and childbearing. (The research for this report was concluded before the post-election violence that started at the end of 2007. That violence only exacerbated the difficulties of accessing HIV-related care for many women.[10])

The report also documents some of the structural barriers that interfere with the provision of quality care by health care providers. These obstacles include insufficient training about both HIV in general and specialised care for HIV-positive women, as well as the lack of necessary protective equipment and post-exposure prophylaxis to ensure that providers can take universal precautions to protect themselves against contracting HIV in the workplace.

These types of rights violations have serious ramifications for the government's efforts to reduce the spread of HIV in Kenya. Negative experiences with the health care system can discourage HIV-positive women from obtaining professional care; instead, they seek care from informal sources, such as traditional birth attendants, who are frequently even less equipped to attend to the reproductive health needs of HIV-positive women. One woman who was tested for HIV without her consent declined to receive the results from her doctor. She stated: "I told him that I would come for them later as they had taken blood samples without permission. I felt this was wrong treatment from the hospital."[11] Moreover, lack of appropriate treatment and information regarding PMTCT can increase the risk of transmission to children. As one health care provider admitted, "The obstetrics services to ensure no transmission [between mother and child are] not followed and there is that 'don't care' attitude. And I don't know what can be done to ensure the woman gets proper services."[12]

The findings of this report are also highly relevant to the legislative framework around HIV that is in the process of being adopted in Kenya. The 2006 HIV and AIDS Prevention and Control Act (HIV Act)[13] was gazetted on January 2, 2007, but is not yet operational. The act provides measures for the "prevention, management and control of HIV and AIDS," as well as for "the protection and promotion of public health and for the appropriate treatment, counselling, support and care of persons infected or at risk of HIV and AIDS infection."[14] While it contains many positive and useful provisions, the HIV Act does not offer uniformly strong protection for the human rights of those living with and affected

by HIV. It allows for partner disclosure by health care providers without the client's consent[15] and criminalizes situations where a person knows his or her status and fails to take "reasonable measures and precautions to prevent the transmission of HIV to others" or does not divulge this status prior to sexual contact or needle sharing.[16] Similarly, the act imposes criminal and financial penalties on any HIV-positive person who knows his or her status and, "knowingly or recklessly, places another person at risk of becoming infected with HIV unless that other person knew that fact and voluntarily accepted the risk of being infected."[17]

These provisions are troubling on a number of fronts; by undermining the right to confidentiality they can deter people from being tested and seeking treatment for HIV, and they do not take into account the many reasons why one may not be in a position to reveal one's status to a partner or be able to engage in safer sex practices. The HIV Act, as it stands now, risks subjecting HIV-positive women, who are already vulnerable to human rights violations, to further abuses. Since testing is a common element of antenatal care, it is more likely that the HIV status of women will be disclosed to their partners without their consent under this act. As this report documents, when women are tested for HIV without their consent, they are denied the right to make an informed choice about testing that takes into account the possibility of involuntary partner disclosure. Furthermore, as is discussed below, women whose partners learn that they are HIV positive may fall victim to domestic violence and abandonment. The HIV Act's broad criminalization of HIV transmission also raises serious questions about the meaning of this term in the context of PMTCT, particularly when it is clear that women often lack the information and services necessary to prevent transmission to their babies. This report emphasises that the government's goal of reducing the spread of HIV and improving public health would be much better addressed by eliminating existing weaknesses in the health care system and ensuring that the rights of HIV-positive people are respected and protected by health care professionals.

Methodology

This supplement includes additional research, interviews, and focus group discussions conducted between May 2007 and December 2007. In addition, it draws upon the FIDA Kenya/CRR research and interviews conducted for *Failure to Deliver* between November 2006 and May 2007.

For *Failure to Deliver*, FIDA Kenya/CRR gathered the experiences of more than 120 women through a combination of in-depth interviews, focus-group discussions, and questionnaires. Information was collected from women currently living in and around Nairobi and Nyanza provinces, but the participants recounted experiences that they had in the majority of Kenya's provinces and in a range of facilities, from private clinics to district, provincial, and national public hospitals. Interviewees and focus group participants were identified through health care providers, community-based organisations, and other participants. Some were FIDA Kenya clients or women seeking legal advice from FIDA Kenya. Questionnaires were distributed to women who sought legal services at FIDA Kenya offices in Kisumu and Nairobi.

FIDA Kenya/CRR also conducted site visits to private and public facilities and spoke to health care providers and administrators, leaders of medical associations, and officials at licensing and regulatory bodies, in addition to reviewing government guidelines, standards, and manuals pertaining to reproductive health services and media coverage of reproductive health issues from the past ten years.

The interviews and site visits that were conducted for *Failure to Deliver* were supplemented by interviews with the National Coordinating Agency for Population and Development (NCAPD), the National AIDS Control Council (NACC), the National AIDS/STD, TB and Leprosy Control Programme (NASCOP), and nongovernmental organisations (NGOs) working with HIV. Additionally, FIDA Kenya/CRR reviewed government guidelines, standards, and manuals on issues pertaining to HIV/AIDS. Data from the 2003 Kenya Demographic Health Survey, the 2004 Kenya Service Provision Assessment Survey, and the 2005 Kenya Health Workers Survey has been used both to provide a national perspective on reproductive health and to corroborate specific rights violations. Two additional focus groups with a total of 36 HIV-positive women, which were organised by the Victory Post-Test Group under the umbrella of Liverpool VCT, were held in Kisumu. To protect the confidentiality of the women who shared their experiences with FIDA Kenya/CRR, their real names are not used in either report.

Scope and Structure of the Report

This report is not an exhaustive examination of the many abuses and violations that HIV-positive women encounter in Kenya, both within and outside of the health care system. It does not encompass HIV-positive women's experiences with all reproductive health services or all HIV-related services, but focuses primarily on issues around testing, counselling, and service provision, particularly in the context of prenatal and delivery services.

Section One discusses violations that stem from testing and counselling and inadequate confidentiality protections, followed by Section Two, a brief inset on the violations women encounter when seeking HIV/AIDS treatment. Section Three examines the specific implications of structural barriers to quality care for women living with HIV, while Section Four discusses some of the forms of discrimination and stigma that HIV-positive women encounter, with an eye to how such conduct can impair women's access to necessary health care services. Section Five provides an overview of the legal implications of the rights violations identified in the report. Recommendations to key stakeholders, based on input from the women, medical providers, HIV/AIDS counsellors, NGO members, and officials with whom FIDA Kenya/CRR spoke, are included at the end of the report.

Violations Around Testing, Confidentiality, and Counselling

HIV Testing and Informed Consent

Providing adequate and accessible HIV testing and counselling is the first step in enabling HIV-positive women to fully exercise their reproductive rights.[18] Women who know their HIV sero-status can receive reproductive health care and counselling that is appropriately tailored to assist them "in making decisions on such issues as the number, spacing and timing of pregnancies, use of contraceptive methods and infant-feeding practices."[19]

Testing to determine one's sero-status and counselling about HIV/AIDS and reproductive health are particularly important for women who intend to conceive or are already pregnant. Women who are HIV positive and aware of their sero-status can make informed decisions about the effects of a pregnancy on their health and take appropriate steps to prevent the transmission of HIV to their children. According to the Kenyan Ministry of Health,

> *HIV infection has emerged in Kenya as the most important health risk factor for mother and baby. HIV infection has the greatest impact of any health condition on the long-term outcome of pregnancy and child survival. Therefore, all pregnant women should be encouraged to learn their HIV infection status. . . . Only by knowing HIV status can the health worker make appropriate health care management recommendations and the pregnant woman make appropriate decisions about maintaining her health.*[20]

In order to ensure the success of HIV testing, "testing must be grounded in an approach that protects human rights and respects ethical principles so that [it] is confidential, accompanied by counselling and only conducted with informed consent."[21] A paramount factor in ensuring appropriate testing services that enable women to make informed reproductive choices is to secure every client's informed consent to HIV testing. The United Nations Population Fund (UNFPA), World Health Organisation (WHO), and other international human rights treaties and bodies have underscored the importance of informed consent.[22] The International Guidelines on HIV/AIDS and Human Rights [International Guidelines],[23] which were issued by UNAIDS and the Office of the High Commissioner of Human Rights (OHCHR) and clarify the application of human rights instruments to the context of AIDS, mandate that "public health legislation should ensure that HIV testing of individuals should only be performed with the specific informed consent of that individual."[24] However, as a leading international human rights organisation has observed,

> *testing is also open to abuse and denial of human rights. Abuses include introduction of mandatory screening and compulsory testing, failure to obtain consent to testing, failure to provide adequate pre- and post-test counselling; failure to respect confidentiality, failure to inform the tested person of the outcome of the test and testing people on discriminatory grounds.*[25]

ELEMENTS OF INFORMED CONSENT

The international human rights framework and Kenyan policies mandate that patients provide their informed consent to health care procedures.[26] In the health care context, the components of informed consent include:

- consent to a medical intervention that is "obtained freely, without threats or improper inducements";[27]
- consent that is both informed and voluntary;[28] and
- "consent given without any force, fraud or threat and with full knowledge and understanding of the medical and social consequences of the matter to which the consent relates."[29]

Patients should receive information that is:

- adequate and understandable to the patient;[30]
- "in a form and language understood by the patient,"[31] which minimizes the use of unfamiliar technical terminology and ensures some form of interpretation, if language barriers are present;[32]
- clear about the purpose of the treatment;
- detailed about the possible benefits of treatment;[33] and alternative treatments, including the effect of non-treatment;[34]
- clear about the potential risks of treatment,[35] including "possible pain or discomfort, risks and side-effects of the proposed treatment";[36] and
- offered by properly trained personnel.[37]

Existing Laws and Policies

Pregnant women in Kenya may access testing to determine their HIV sero-status at antenatal clinics in conjunction with other antenatal services, with Diagnostic Testing and Counselling (DTC)[38] for opportunistic infections, or they may independently seek this service at a Voluntary Counselling and Testing for HIV (VCT) centre.[39] The Kenyan government has produced a number of key documents outlining how testing and counselling should be provided in these contexts and in general, and which contain a range of rights protections.

The HIV and AIDS Prevention and Control Act [HIV Act] codifies measures for "appropriate treatment, counselling, support and care of persons infected or at risk of HIV and AIDS infection."[40] The act received presidential assent on December 30, 2006, and was gazetted on January 2, 2007. However, at the time of the publication of this report, the appropriate ministry had not yet made the HIV Act fully operational by determining a date of commencement. In recognition of possible abuses, one of the objects and purposes of the HIV Act is to "prohibit compulsory HIV testing. . . ."[41] The act provides that "no person shall compel another to undergo an HIV test."[42] Additionally, Section 14 reiterates that ". . . no person shall undertake an HIV test in respect of another person except – (a) with the informed consent of that person."[43] According to the HIV Act, "consent" means "consent given without any force, fraud or threat and with full knowledge and understanding of the medical and social consequences of the matter to which the consent relates."[44]

Additionally, the Ministry of Health issued the National Guidelines for Voluntary Counselling and Testing (VCT Guidelines) in 2001[45] and the National Guidelines: Prevention of Mother-to-Child HIV/AIDS Transmission (PMTCT Guidelines)[46] in 2002, which delineate the scope and standards of care

that patients, particularly pregnant women, should receive in this area. These guidelines are intended to "assist all facilities . . . in Kenya, including Government of Kenya hospitals and health centres, private, mission, and NGO [nongovernmental organisation] hospitals and health centres."[47]

Kenya's VCT Guidelines, which govern the provision of voluntary counselling and testing for HIV for both public and private testing providers,[48] require that "[b]ecause using these services is voluntary, the consent of the client to have the counselling and testing must be informed. The service provider must ensure that there is no coercion."[49] In the case of pregnant women, the VCT Guidelines state that "[t]he counselor must ensure that the mother thoroughly understands the benefits and risks of HIV testing and understands the additional services she will receive if HIV positive."[50] The PMTCT Guidelines stress that "HIV testing in the antenatal clinic should be routine, just like the other tests. . . . All of these tests . . . should never be performed without consent, and pregnant women must be allowed the opportunity to 'opt-out' and to decline these services."[51] In contrast to VCT, which is initiated by the client seeking to determine his or her HIV status, routine-offer testing, also referred to as provider-initiated testing, means that a patient seeking treatment will receive an HIV test as part of a comprehensive package of services unless he or she specifically declines or "opts out" of the test.[52]

Violations of Informed Consent

However, the protections of informed consent described above are not always realised in practice, particularly when women are seeking maternal health care. The Kenya Service Provision Assessment Survey [2004 KSPAS] indicates that only 50% of Kenyan facilities—and only 15% of the nation's maternity facilities—follow the informed consent for testing policy articulated in the VCT Guidelines policy.[53] And, according to the Preparedness for HIV/AIDS service delivery: The 2005 Kenya Health Workers Survey conducted by NASCOP and the Ministry of Health, approximately 20% of health care workers felt that it was appropriate to test patients for HIV without their knowledge, and "[p]roviders in maternity homes were nearly twice as likely as other providers to feel that testing patients without their knowledge was appropriate."[54] These responses demonstrate that the VCT and PMTCT Guidelines are not being adequately explained or implemented by either the Ministry of Health or health care providers.

Women and service providers indicated that for many women, opting out of an HIV test was not a viable option. To the contrary, some women are tested for HIV without their consent or knowledge. According to Prudence, a casual worker (non-medical member of the staff) in a delivery ward in a Kisumu district hospital,

> *if you go to [the antenatal] clinic, you are asked to have a test, but [if] the wom[a]n refuse[s] . . . the nurse do[es] the test secretly. . . . When you go to the clinic the first time [the woman] go[es] for testing and [is] told [the testing] is for malaria or blood group, etc. You will think they are testing for malaria. But if you cooperate [it] is okay. They will do PMCT [prevention of mother to child transmission]. . . . But if you refuse they deal with you accordingly . . . since you cannot force patients to be tested, it is done secretly.*[55]

Prudence stated that women are tested for HIV without their consent "for diagnostic reasons. This is to protect the unborn baby and for the ones handling the mother."[56]

*"**PROVIDERS IN MATERNITY HOMES** were nearly twice as likely as other providers to feel that testing patients without their knowledge was appropriate."*

*"**SOMETIMES THE MOTHER WANTS TO OPT OUT** but she is not given a chance. She is tested against her wishes."*

Additionally, Jennifer, a service provider at New Nyanza Provincial Hospital, informally referred to as Russia, explained that some service providers either force women to take an HIV test or order this test without their consent. She stated that "[s]ometimes the mother want[s] to opt out but she is not given a chance. She is tested against her wishes."[57] Thus, regardless of the "opt-out" policy put forth in Kenya's PMTCT Guidelines, Kenyan women cannot necessarily exercise this option. Women who have expressly opted out may nevertheless be forced to submit to an HIV test, or health care providers may secretly test their blood for the presence of HIV.

Allan A. Maleche, a lawyer at Kenya Ethical and Legal Issues Network on HIV and AIDS (KELIN), a legal nongovernmental organisation, further discussed the practices to which pregnant women are subjected in order to ensure that they consent to undergo an HIV test.[58] He explained that health care providers are often seen as all-knowing and it can be difficult to refuse their recommendations: "you'll be coerced to understand that you can't say no to this medical procedure. . . . The decision will not be conscious. It will be influenced . . . it will be hard to refuse easily."[59]

Key government officials with whom FIDA Kenya/CRR spoke expressed confusion regarding Kenya's policy of routine or "opt-out" testing and suggested that mandatory or compulsory HIV testing is an element of the antenatal treatment offered at Kenyan health care facilities. The fact that these officials maintain that antenatal treatment includes a compulsory HIV test indicates confusion about the status of PMTCT testing and a lack of effective implementation of the PMTCT Guidelines. For example, an official at the National AIDS/STD, TB and Leprosy Control Programme (NASCOP), the agency that drafted the PMTCT and VCT Guidelines, stated that "[e]very mother visiting [an antenatal clinic] is tested for HIV on a routine basis." He explained that women receive the results of their HIV tests, regardless of whether or not they would like to receive them but that health care facilities subsequently provide these women with the option to opt out of treatment if they are HIV positive. According to this official, "PMCT is geared toward the child. The main focus is not even the mother, it's the child … The goal is to protect the unborn child if the mother is positive."[60]

Charles Oisebe, the Senior Population Officer at the National Coordinating Agency for Population and Development (NCAPD), remarked that all women who seek antenatal services are compulsorily tested for HIV, and that they may not even be informed of the testing.[61] Steven Malai, the Communications Officer-Advocacy at the National AIDS Control Council (NACC), described the practices employed to ensure that women are tested for HIV. Malai explained that although pregnant women are given the option to have their blood tested for HIV, if they are unready to do so, the counselling process will continue until they agree to undergo testing.[62] According to Malai, there have been no cases where a woman has refused to undergo an HIV test following such counselling.[63]

Edith Atieno, a VCT counsellor at Women Fighting AIDS in Kenya (WOFAK), an organisation which provides support services to HIV-positive women, confirmed the implied policy that pregnant women are compulsorily tested for HIV, remarking that in the "government today, they have to test you. It's not consensual. . . . If you refuse, they continue to make you come back until you agree [to be tested]."[64] Atieno explained that the rationale behind this policy is that the nurses and doctors assisting in the delivery of the baby are at risk if they do not know the HIV status of the pregnant women. According to Atieno, if the nurses and doctors know the HIV status of their pregnant patients, they can assist HIV-positive women during their deliveries.[65] Atieno also noted that at private hospitals, VCT counsellors often did not seek the consent of pregnant women before testing their

blood samples for HIV. She explained that a private hospital will sometimes test a pregnant woman for HIV, regardless of whether or not she has given her consent, and furthermore, she may not be informed of the results of the test, but her doctor will be informed of her sero-status.[66]

These testimonies reflect that testing without consent occurs in part because of the perception that health care providers must learn of the HIV status of their patients in order to adequately protect themselves against the transmission of the virus. However, hospital staff should take universal precautions to prevent against the transmission of disease when treating any patient and they should have the necessary supplies and equipment to do so. The HIV Act emphasizes that the Ministry of Health "shall at all times, ensure the provision of protective equipment such as gloves, goggles and gowns" and "post exposure prophylaxis to healthcare providers and other personnel exposed to the risk of HIV infection."[67]

The standard of care provided to patients should not be tailored to the HIV sero-status of the patient. According to the PMTCT Guidelines, "Women with HIV should not be isolated or treated differently from other women in labour. Universal precautions . . . should be used by health workers on all women in labour irrespective of their HIV status."[68] The ART Guidelines echo this position: "The risk of exposure to HIV contaminated blood or bodily fluids should be minimised by using universal precautions. This means that all blood should be treated *as if contaminated with HIV.*"[69] Therefore, testing to determine the sero-status of women who are pregnant in order to provide them with a different standard of care than they would otherwise receive is impermissible.

However, Kenyan health care facilities routinely experience a shortage of supplies, as documented in both *Failure to Deliver*[70] and Section Three of this report, which can prevent health care workers from taking universal precautions to protect themselves when they treat their patients. When hospitals lack the necessary protective supplies such as gloves and HIV post-exposure prophylaxis these health care providers may be reluctant to treat patients without actual knowledge that the patients are HIV negative. And when health care providers know their patients are HIV positive but lack the proper equipment to protect themselves, they may not provide care to those patients at all.[71] (See Inadequate Service Provision section.)

Allan A. Maleche, a lawyer at KELIN, verified that testing for HIV without the informed consent of the patient is a frequent occurrence, and that some health care professionals will subject a patient to an HIV test without her consent or knowledge if the health care professional pricks himself or herself while providing treatment.[72] "Doctors say if I accidentally prick myself, I definitely have to test my patient, whether she likes it or not."[73] In this scenario, the doctor will rarely inform the patient that her blood has been tested for HIV.[74] This practice is unethical under the ART Guidelines:

> *Whether or not antiretroviral prophylaxis is prescribed after an occupational exposure to HIV is based on a risk assessment. . . . Both the source and exposed [health care worker] need to be counselled for HIV-testing. <u>Known</u> source should be tested for HIV; [i]f the source declines to be tested they should not be coerced into having the test."*[75]

*"**PMCT IS GEARED TOWARD THE CHILD.** The main focus is not even the mother, it's the child … The goal is to protect the unborn child if the mother is positive."*

The ART Guidelines do not allow the patient to be tested for HIV without counselling and the provision of her informed consent, even if the health care provider is exposed to the blood or bodily fluids of the patient. The health care provider should conduct a risk assessment of the exposure and determine

whether post-exposure prophylaxis is necessary, regardless of the sero-status of the patient.[76] However, if health care providers are unable to take this universal precaution because the hospital is experiencing a shortage of the medication, the lack of prophylaxis may prompt health care providers to seek to discover the HIV sero-status of their patients before providing treatment to them.

Impact of Testing Without Consent

Testing pregnant women for HIV without their consent, regardless of the motivation, has grave human rights and public health implications. In addition to violating women's human rights, it can diminish women's confidence in the health care and undermine the government's efforts to improve maternal health and scale up the use of PMTCT programmes.

PMTCT programmes seriously curtail the reproductive rights and privacy of women when they violate a woman's right to informed consent to testing and privilege the interest of the state in the health of the child above the autonomy of the pregnant woman. According to a scholar in this field,

> *[m]andatory HIV testing in any situation is the most problematic of any testing strategy . . . it involves very significant limitations of individual autonomy and deep incursions into the domain of individual privacy. In pregnancy . . . mandatory HIV testing threatens to create a situation where [the woman's] moral value is secondary to that of her yet-to-be-born-child. The most serious objection to mandatory testing schemes is the denial of dignity.*[77]

In this context, the autonomy of the woman to reach her own decisions is replaced by another objective, and the woman thereby "becomes a means to some other end and is no longer respected or empowered as an end in . . . herself."[78] According to UNFPA and WHO, "programmes to prevent mother-to-child transmission that consider women as merely the bearers of children and not as individuals requiring care and treatment risk both violating women's rights and failing to attract many participants."[79] The failure of PMTCT programmes with mandatory testing components is further examined later in this section.

The International Guidelines consider mandatory HIV testing in PMTCT programmes to be a coercive measure that is ineffective in combating the spread of this virus and restricts the human rights of the individual.[80] According to the International Guidelines, "[m]any HIV programmes targeting women are focused on pregnant women but these programmes often emphasise coercive measures directed toward the risk of transmitting HIV to the foetus, such as mandatory pre- and post-natal testing."[81] Ultimately, these programmes "result in reduced participation and increased alienation of those at risk of infection"[82] and "these coercive measures drive people away from prevention and care programmes, thereby limiting the effectiveness of public health outreach."[83]

For the Kenyan government's efforts to encourage pregnant women to learn of their HIV status and use health facilities during birth to succeed, they must create a supportive environment for HIV testing. According to one human rights advocate, "[e]xperience has shown that, where women are properly counseled and well informed of the benefits of HIV testing during their antenatal care, they are more likely to cooperate than if they are coerced into HIV testing."[84] Therefore, the government must address the reasons that lead women to forego HIV testing, and allay the concerns of these women in a supportive manner. One scholar described some of these factors:

> *The reasons for not wanting to test involve fear: fear of stigma and discrimination, fear of loss of confidentiality, privacy, employment and other benefits, and fear of violence and rejection within families and communities. Clearly during pregnancy women do not arbitrarily choose both to not know their own health status and to put the health status of future children at risk. There are motivating factors at play related to the wider social context in which these women and children live.*[85]

Kenyan health facilities that neglect to address the concerns of women with these fears about HIV testing fail to create a supportive environment for HIV testing, and risk alienating these women from the Kenyan health care system. (See Discrimination section.)

Such an outcome is counter-productive to the Kenyan government's commitment in its National Reproductive Health Strategy to reduce the rate of maternal mortality in Kenya by ensuring the presence of skilled attendants during 90% of deliveries by 2010.[86] If the government seeks to increase deliveries at health care facilities with skilled attendants, rather than with the assistance of traditional birth attendants (TBAs) in their own homes, women must trust the public health care system enough to use it, or they may opt to seek care from more informal and potentially under-qualified sources. Reliance on TBAs can create a greater risk of HIV transmission, both to the children being delivered and to the birth attendant. According to Maleche, the lawyer at KELIN, many midwives or traditional birth attendants who assist women during delivery lack knowledge about either the transmission of HIV or the use of appropriate protective gear.[87] Maleche added that even when TBAs understand the means by which HIV transmission occurs, they may continue to assist women living with HIV to deliver their children, despite the absence of adequate protective gear, because this work "puts food on the table."[88] Moreover, in resource-constrained settings such as Kenya, where even large health care facilities struggle to provide protective gear to health care workers, TBAs may face significant challenges in securing this equipment, and therefore forego its use.

Violations of Confidentiality and Lack of Proper Disclosure

As discussed above, Kenyan women are sometimes tested for HIV without their informed consent or knowledge, which compromises their autonomy and their privacy. According to UNFPA and WHO, "[t]he HIV status of women should be kept confidential and their medical records available only to health workers with a direct role in their care or care for their infants."[89] Unfortunately, Kenyan women often experience violations of their rights to confidentiality and privacy in regard to their HIV/AIDS status at the hands of health care providers.

FIDA Kenya/CRR interviewed several women for this report who sought treatment at public hospitals and only discovered that they had received an HIV test when they overheard a health care professional discussing their sero-status with others. This practice violates the HIV Act, which requires that "[t]he result of an HIV test shall be confidential and shall only be released – (a) to the tested person."[90] Additionally, the VCT Guidelines stress the importance of maintaining confidentiality in relation to HIV testing: "[i]t is essential that confidentiality be maintained through strict controls when conducting HIV counselling and testing. . . . HIV results should be disclosed only to the client."[91] When health care providers discuss the HIV status of a patient in the presence of other individuals, they compromise these confidentiality guarantees.

*"**THEY HAD TAKEN BLOOD SAMPLES** without permission. I felt this was wrong treatment from the hospital."*

Women with whom FIDA Kenya/CRR spoke described being tested without their knowledge and consent and learning their HIV status by overhearing health care providers talking among themselves. Christine recounted her experience:

> *No one informed [me] of the intention [to] screen the blood for HIV. I kept quiet; [the doctors] came and surrounded me while I lay on the bed as they discussed my status in medical language without explaining to me about my status. They did not tell me of my status but they kept asking me how I was feeling and which part of my body was ailing. . . . When I was discharged, one doctor took me to a room and I knew he wanted to inform me of the results of the test but I told him that I would come for them later as they had taken blood samples without permission. I felt this was wrong treatment from the hospital.*[92]

Enid, a woman who had a similar experience with physicians at a district hospital in Kisumu in 2001, was tested for HIV without her consent and only learned that she was HIV positive by overhearing a conversation among health care professionals who were discussing her sero-status during their rounds. She was never personally informed of the results of her HIV test. During the dispensation of medication to patients, Enid was administered Septrin, an antibiotic often given to HIV-positive patients in order to decrease their risk of contracting pneumonia, by a nurse who simply commented that Enid was HIV positive. Enid received no counselling about HIV/AIDS in conjunction with the distribution of medicine, and left the hospital.[93]

The 2004 KSPAS reported that only 39% of facilities in Kenya observed the confidentiality policies articulated in the VCT, PMTCT or Antiretroviral Treatment (ART) Guidelines.[94] A doctor who works at Kenyatta National Hospital confirmed that it can be difficult to keep one's HIV status confidential in large facilities.[95] He noted that the sero-status of a patient is often discussed among health care staff during rounds, and other patients may easily overhear these conversations.[96] Prudence, a casual worker in the delivery ward of a district hospital in Kisumu, explained that nurses often disclose the HIV sero-status of patients to other hospital staff.

> *[The nurses] know this one is positive and this one is negative. They tell us. . . . There is no confidentiality because even us [the casual workers], we get to know. We are told because we are like staff and we are the ones who handle things. . . .*[97]

The reality that non-medical staff at Kenyan health facilities learn of the HIV sero-status of patients and even provide services to these patients demonstrates the widespread ramifications of understaffing that health facilities throughout Kenya experience. The reliance of health care providers on support staff to provide treatment to patients not only leads to lower-quality services for women and their babies, as documented in *Failure to Deliver*,[98] but also results in breaches of patients' privacy rights.

International human rights standards[99] and the HIV Act guarantee each patient the right to confidentiality. The provisions of the HIV Act demand that "[n]o person shall disclose any information concerning the result of an HIV test or any related assessments to any other person."[100] The act delineates certain circumstances under which the sero-status of a patient can be disclosed, but none of these provisions are relevant to the context in which the sero-status of a patient is publicly discussed

in the presence of other patients at a health care facility or disclosed to hospital staff without the written consent of the patient.[101] The failure of health care professionals to discuss the HIV/AIDS status of their patients in a private setting violates patients' rights to confidentiality and privacy.

Violations Around Counselling

Counselling women about HIV/AIDS allows them to make informed reproductive choices. For women who are HIV negative, access to testing and counselling services is important because it "offers an opportunity . . . to counsel women about the importance of staying negative and providing information on how to do so."[102] For women planning to conceive or who are already pregnant, adequate counselling about their HIV status will enable them to protect their health, and to receive proper antenatal treatment and take steps to prevent mother-to-child transmission of HIV, if necessary. UNFPA and WHO emphasise that because of the potential risks that pregnancy may pose to the health of HIV-positive women and their infants, "special counselling and support should therefore be provided to HIV-positive women living with HIV/AIDS planning a pregnancy."[103]

Inadequate Pre- and Post- Test Counselling for HIV Testing

Appropriate counselling services provide both pre- and post-test counselling. The International Guidelines encourage states to offer "pre- and post-test counselling . . . in all cases."[104] Kenya's HIV Act requires that "[e]very testing centre shall provide pre-test and post-test counselling to a person undergoing an HIV test. . . ."[105] Pre-test counselling should include information about the benefits of voluntary testing, and the follow-up services that are available.[106] The 2005 Kenya Health Workers Survey demonstrates the weakness of Kenya's health care system in this area. According to this survey, approximately "80 percent of respondents [] felt they needed further training on how to recommend an HIV test to a patient …"[107]

The VCT Guidelines highlight the importance of counselling pregnant women so that they can learn their HIV status and begin accessing PMTCT services:

> *VCT service sites, especially those in health facilities, may serve as the entry point for antenatal mothers to be screened for HIV, and then enrolled in PMCT programmes. . . . Unlike the situation in stand-alone VCT sites, pregnant women may have come to the site for regular ANC [antenatal care] services and may not be expecting or requesting HIV testing. The counselor must ensure that the mother thoroughly understands the benefits and risks of HIV testing and understands the additional services she will receive if HIV positive.*[108]

When women seek ANC services, the PMTCT Guidelines recognise that

> *the pregnant woman is seeking medical care to ensure her baby's health and her own health. HIV testing and counselling is at best a secondary purpose for seeking care. Therefore counselling and testing [for HIV] in the antenatal clinic is recommended by the health worker as part of a comprehensive package of care.*[109]

Furthermore, the PMTCT Guidelines elaborate the standards of adequate counselling that health care providers must adhere to when advising pregnant women about HIV:

THE PMTCT GUIDELINES SPECIFY *that counselling should include the following five components: information; pre-test or consent counselling; risk assessment/ prevention counselling; post-test or results counselling; and, patient management.*

> *Counselling is an important part of a health worker's job, and every patient encounter should include counselling. The information provided should be accurate, appropriate for the condition or stage in pregnancy, and should be communicated clearly in language, which the pregnant woman can understand. Counselling is two-directional; active listening is equally as important as informing.*[110]

In the context of antenatal care, the PMTCT Guidelines specify that counselling should include the following five components: information; pre-test or consent counselling; risk assessment/prevention counselling; post-test or results counselling; and, patient management.[111] Inadequate counselling and information that do not meet these criteria are significant barriers for women seeking to understand their HIV status and its consequences for childbearing. Women interviewed by FIDA Kenya/CRR indicated that health care professionals did not adequately inform and counsel them about the importance of taking an HIV test in preparation for childbirth. Sarah, who delivered at a Kisumu district hospital, stated,

> *I had my last child in 2000 in the District hospital. At the time I did not know of my status. . . . I learned of [my] HIV status after I was discharged. I was very shocked, because in 2000, there was a lot of information on HIV but I was not told this. . . . After months of breastfeeding the baby, that is when I discovered my status. I stopped breastfeeding immediately.*[112]

Ann, who echoed the opinion of many women who had delivered at a Kisumu district hospital, stated that women were not offered adequate counselling in preparation for testing.[113] Instead, she and other women maintained that the counsellors' "main interest is to test. They have an objective. It's like a research [rather] than helping someone. I later realised it was lack of knowledge; they should employ people who have more knowledge in what they do."[114] Ann stressed the importance to women of pre-test counselling:

> *It is not good for people to be tested without their consent. It is good to give knowledge on the importance [of testing] because if the woman gives birth to a positive child the burden is still on her. . . . If women are given the knowledge . . . before they get pregnant it is easier to handle one person with HIV rather than mother and child. . . . For me, I knew my status when pregnant so I had refused [that] my child would [be] infected. . . . It is also important to know your status even before you become pregnant so that you can at least know the ways of not letting the baby get infected.*[115]

Post-test counselling in Kenya is often deficient, as well. According to the HIV Act, "post-test counselling" refers to the process of providing a person who submitted themselves for an HIV test with risk-reduction information and emotional support at the time the test result is released."[116] Jennifer, a health care worker at New Nyanza Provincial Hospital, explained that women who have undergone an HIV test, either voluntarily or without their consent, are informed that they are HIV-positive without the benefit of proper counselling that would enable them to understand the effects and impact of testing positive.[117] Indeed, Jennifer noted that many women experience shock and denial because the information that they receive about their HIV status is not accompanied by adequate education and support.[118]

Furthermore, some women complained about the attitude of the nurses who conduct the HIV tests. These women suspected that the goal of the nurses was solely to conduct the HIV tests, but not to provide adequate post-test information and counselling. For instance, Ann described her experience, as well as the experiences of other women, with post-test counselling at a government district hospital:

> *About the nurses' attitude—especially patient support at the district hospital—what I have seen personally [is that] if a person goes there and [is] tested and found to be positive, [the nurses] only follow you up until the time you are tested like you would think [it] is their objective to report on how many people were tested. They later will not treat you well.*[119]

This practice contravenes the purpose of the VCT Guidelines, which instruct counsellors that "[e]very opportunity should be given to allow the client to express their feelings about the test results and any other personal issue. There should be ample time for the client to ask questions about the meaning of the test results and any other issues."[120] Similarly, the PMTCT Guidelines state, "Learning of HIV positive results can be shocking" and call on the nurse/counsellor to discuss the following with the patient: coping with feelings of shock and loss; the difference between HIV and AIDS; infection prevention and care; PMTCT through ongoing care and ARVs for the mother and baby; and giving encouragement to live positively."[121] The guidelines further instruct that "[i]t is important to establish a rapport that will encourage the client to feel comfortable at return visits, ideally seeing the same nurse/counsellor."[122] Yet, as with the weakness in pre-test counselling, Kenya's health care providers also reported that they required additional training in the provision of post-test counselling for both HIV positive and negative patients.[123]

The provision of appropriate pre- and post-test counselling is a major obstacle to quality care, which Kenya's health care providers must address. The 2004 KSPAS reported that the policies for pre- and post-test counselling articulated in the guidelines are only observed in 45% of clinics throughout Kenya, with only 13% adherence in maternity clinics.[124] This lack of proper counselling places the lives and health of Kenyan women at risk because patients who do not receive adequate information about their sero-status and HIV may forego treatment for this illness.

Inadequate PMTCT and Post-Partum Counselling

While discussing counselling with FIDA Kenya/CRR, women particularly lamented the unwillingness of health care workers to respond to their questions about HIV/AIDS and the ways in which they could avoid transmitting the virus to their children. According to the 2004 KSPAS, only 24% of Kenyan facilities offer PMTCT services.[125] The major cause of HIV/AIDS among children is transmission during pregnancy, delivery, and breast-feeding.[126] In the absence of any intervention, children who are born to HIV-positive women have a 5-10% risk of acquiring HIV during pregnancy, a 10-20% risk of acquiring HIV during labour or delivery, and a 5-20% risk of acquiring HIV while breastfeeding.[127] Treating an HIV-positive mother with antiretroviral medication during pregnancy and labour, as well as treating the child after birth, can decrease the risks of HIV contraction to 2%.[128]

Although the WHO's general recommendations for the prevention of mother-to-child transmission are to deliver the baby by caesarean section, provide antiretroviral treatment to both the mother and the baby, and refrain from breastfeeding by using formula, these safeguards are often not possible in resource-constrained settings such as Kenya.[129] In most Kenyan health facilities, elective

"I THINK IT WAS MORE GUIDANCE AND NOT COUNSELLING *because you are put in room and told things. I asked her the risks involved in exclusive breastfeeding and the nurses just told me to [choose] and stop asking a lot of questions."*

caesarean sections are not available for women living with HIV. Issues around feeding practices for babies born to HIV-positive mothers are particularly complex as refraining from breastfeeding is not feasible because women may not have access to the funds with which to purchase formula or uncontaminated water with which to mix it. Currently, the PMTCT Guidelines recommend that "[b]abies should be exclusively breastfed for the first 6 months of life. There is early evidence that mixed feeding [between breast milk and formula] increases the risk of breastmilk transmission of HIV."[130] The PMTCT Guidelines specifically note the importance of counselling on this issue, stating, "Women should be counselled about the different possible infant feeding alternatives. We need to respect the mother's choice of infant feeding. . . ."[131] UNFPA and WHO echo these recommendations.[132] Proper counselling on this issue is vital, as women may find themselves caught between advice from providers not to breastfeed and the cost of and stigma associated with formula feeding; these competing pressures can increase the risk of mixed feeding.

The International Guidelines specify that "[s]tates should ensure that all women and girls of the child-bearing age have access to accurate and comprehensive information and counselling on the prevention of HIV transmission and the risk of vertical transmission of HIV, as well as access to the available resources to minimize that risk, or to proceed with childbirth, if they so choose."[133] Adequate counselling around this issue includes counselling during the postnatal period, which lasts at least six weeks, during which a woman should receive "ongoing infant-feeding counselling and support for the woman's choice of how to feed her baby."[134]

Despite the importance of such counselling, the women with whom FIDA Kenya/CRR spoke recounted that health care providers do not always give patients adequate information to answer their questions about infant-feeding practices. Ann, a woman who delivered her baby at a district hospital in Kisumu in 2004, explained:

> *I came to the clinic and after giving birth we were counselled that if [you] are positive you breastfeed exclusively or you give alternative milk exclusively. . . . I failed to understand what was wrong with mixed feeding. I didn't know how the infection would occur. The counsellor just told me it was my choice. I realised that it was lack of knowledge. They should employ people with information. . . . I think it was more guidance and not counselling because you are put in room and told things. I asked her the risks involved in exclusive breastfeeding and the nurses just told me to [choose] and stop asking a lot of questions.*[135]

Other sources also indicate that there are serious problems both in availability of PMTCT services and training of providers on treating people living with HIV. According to the 2004 KSPAS, less than a fourth of the facilities throughout Kenya even offer PMTCT services[136] while the 2005 Kenya Health Workers Survey, reports that only 57% of surveyed health care workers had read the PMTCT Guidelines.[137] The survey also states that, "many health care providers are involved in the management of AIDS patients without the benefit of relevant training."[138] Only one third of the health care providers surveyed had received training in AIDS patient management, and only 39% of respondents reported that they "felt adequately trained to manage AIDS patients …"[139] (See Barriers to HIV/AIDS Treatment section.)

The HIV Act affirms the government's commitment to "training of healthcare providers on proper information dissemination and education on HIV and AIDS."[140] And, according to the dissemination and implementation plan of the National AIDS/STD, TB and Leprosy Control Programme (NASCOP), the agency that developed the PMTCT Guidelines, health care workers at all health facilities, both public and private, should receive training on the provisions of the Guidelines.[141] The regional offices of NASCOP conduct these trainings, and NASCOP recommends that the trainings occur at least once per quarter.[142] However, a NASCOP official noted that the frequency of the trainings varies from region to region.[143] He further conceded that one of the main gaps in PMTCT care is that not all service providers have been trained regarding the proper administration of PMCT.[144]

A recent country assessment of HIV services in Kenya indicated that "HIV/AIDS policies are [not] disseminated to or implemented by service providers at all levels. . . . Key informants agreed that dissemination of policies on the grassroots level was hampered by high turnover among health professionals, poor communication and supervision, and reduced training opportunities for service providers."[145] One barrier to proper training may be the inadequate supply of the PMTCT Guidelines. NASCOP published a limited number of Guidelines: only 500 copies for each district.[146] As of November 2007, the PMTCT Guidelines were out of stock at the NASCOP national store in Nairobi, the capital of Kenya, and are unavailable online. Furthermore, health care workers surveyed by the 2005 Kenya Health Workers Survey maintained that guidelines about HIV/AIDS care and treatment "were not well distributed at their facility."[147] The difficulty of obtaining these Guidelines can hinder their widespread dissemination and implementation.

An important component of successful HIV-related counselling, including pre- and post-test counselling, as well as PMTCT counselling, is to ensure that the counsellors are representative of the communities with which they work. This promotes a supportive, accessible, and empowering environment for patients living with HIV to undergo testing and seek treatment. According to the International Guidelines, "States should support the development of adequate, accessible and effective HIV-related prevention and care education, information and services by and for vulnerable communities and should actively involve such communities in the design and implementation of these programmes."[148] The guidelines emphasise that "[t]he contribution of . . . people living with HIV is an essential part of the overall national response to the epidemic. . . ."[149]

Ann, whose experience with inadequate counselling about infant feeding is described above, explained the importance of becoming part of a community of women living with HIV:

> *I got interested in this issue when I realised I was positive. I joined WOFAK (Women Fighting AIDS in Kenya). They helped me a lot. I have gone for trainings on PMTCT. I do not want other women to go through what I went through. Whenever I see this counsellor I think she is probably doing the same thing to other women and there is nothing I can do about it.*[150]

Women living with HIV can be particularly effective counsellors for those seeking HIV treatment and testing by creating a supportive environment that can encourage and facilitate the testing and treatment of other women and by sharing their experiences about the realities of living with the virus.

*"**IN AS MUCH AS THEY ARE GIVING DRUGS** they should give . . . counselling. They should guide."*

BARRIERS TO HIV/AIDS TREATMENT

Any comprehensive response to HIV for women involves not just preventing transmission of the virus, but also providing long-term access to antiretroviral (ARV) medications, which are various forms of drugs that "work by different mechanisms but each has the effect of blocking the reproduction of the virus which kills cells forming part of the human immune system."[151] The administration of ARVs can prevent the harmful effects of HIV when administered on a regular basis throughout a HIV-positive person's life.[152]

The failure of the Kenyan government to address the barriers to accessing ARV treatment that Kenyan women experience amounts to a violation of the right to health. The UN Commission on Human Rights adopted a resolution which states that the right to health includes the right to access antiretroviral therapy for HIV.[153] The International Guidelines provide that "[s]tates should take legislative and other measures to ensure that medicines are supplied in adequate quantities and in a timely fashion, and with accurate, current and accessible information regarding their use."[154]

Providing ARVs to women is particularly essential to combating HIV/AIDS in Kenya. According to UNFPA and WHO,

> *Providing antiretroviral therapy to women living with HIV/AIDS reduces their mortality, effectively prevents HIV infection among infants and, by improving maternal health, is likely to increase the survival of children born to women living with HIV/AIDS. Providing antiretroviral therapy for women is an essential component of initiatives to reduce maternal mortality, prevent mother-to-child transmission of HIV and secure the health and sexual well-being of women living with HIV/AIDS.*[155]

Furthermore, "[a]ntiretroviral therapy programmes need to be sensitive to women-specific needs, especially in relation to their sexual and reproductive health."[156] The PMTCT Guidelines state that "[a]ntiretroviral therapy should be available for all HIV positive mothers."[157]

Pregnant women who are HIV positive require specialised ARV treatment in order to prevent the transmission of the virus to the fetus. In Kenya, approximately 20-30% of all antenatal clinic attendees are HIV-positive.[158] In cases where pregnant women are not accessing consistent long-term treatment for ARVs, they should be offered "short courses of single, dual or triple antiretroviral prophylaxis . . . to reduce HIV transmission to infants. Short courses of antiretroviral drugs started late in pregnancy or during labour reduce the risk of in-utero and peripartum HIV transmission two- to three-fold and are used in many resource-constrained settings. . . ."[159] Women who are living with HIV, and particularly pregnant women, face many treatment decisions, and must receive adequate counselling from health care professionals in order to understand their options. According to the 2004 KSPAS, "HIV/AIDS clients receiving antiretroviral treatment (ART) require trained health personnel and regular monitoring of their condition, in order to

ensure that an effective antiretroviral regime is being implemented and that side effects are properly managed."[160]

Inadequate HIV-Treatment Counselling

The women interviewed for this report stated that they did not receive adequate counselling about HIV-treatment decisions. Ann discussed the challenges that she faced in seeking clarification about her HIV-treatment regime:

> *[Y]ou . . . can't ask any question or even why you are being given a certain drug. You will be answered that, 'if you know . . . more than I do, why didn't you treat yourself? Why did you come here?' I think it's good to let a patient know what she is suffering from and give reasons for anything you give the patient instead of putting somebody off.*[161]

Additionally, Judy, an HIV-positive woman who sought treatment at the Provincial Hospital, explained:

> *We do not get good services and [for] people who are on drugs, the care should be comprehensive, like in Uganda, [where] you are given ARV's and also at the same time counselling. Counselling is not [at this hospital]. It should be there. . . . In as much as they are giving drugs they should give . . . counselling. They should guide.*[162]

According to the 2004 KSPAS, "with the exception of NGO-managed facilities, less than half of facilities offering ART have a staff member trained in adherence counselling."[163] Furthermore, the 2005 Kenyan Health Workers Survey indicates that "40 to 50 percent of [medical] personnel [surveyed] did not feel adequately prepared to assess patient readiness for antiretrovirals (ARVs), or to provide adherence counselling."[164]

Additionally, a successful ARV treatment programme must involve people living with HIV as counsellors, in order to foster a supportive environment and community for patients seeking access to ARV treatment. The formation of community support groups for women seeking ARV treatment is also important in encouraging adherence to a treatment regime in the face of other barriers to care.[165]

A SUCCESSFUL ARV TREATMENT PROGRAMME MUST INVOLVE PEOPLE LIVING WITH HIV *as counsellors, in order to foster a supportive environment and community for patients seeking access to ARV treatment.*

Inadequate Access to Treatment

Throughout Kenya, long-term ARV treatment is unavailable to many people who seek HIV treatment. The lack of access to ARVs has a disproportionate impact on women.[166] The prevalence of HIV in Kenya is greater among women than men, and the number of women accessing HIV treatment exceeds that of men.[167] Approximately 58% of HIV-positive Kenyans who are receiving ARVs are women.[168] In 2006, 203,425 Kenyans were eligible for ARV treatment, but only 120,026 people received the medication.[169] According to one NASCOP official, the disparity in these figures is even greater than the official reports.[170] This official

estimated that 430,000 Kenyans are currently in need of ARV treatment, while only 170,000 people have access to this treatment.[171]

Providing adequate access to HIV treatment is a significant struggle for many health care facilities because of challenges in distribution, infrastructure, administration, staffing, and reliable supply of ARVs.[172] Women may encounter a number of barriers when trying to access treatment ranging from the negative attitudes of health care providers to lack of medicine.

Ann noted that women were turned away from counselling sessions and denied medication if they missed a single counselling session: "For example, if you missed the clinic, instead of listening to find out why you didn't come they chase you [away]. . . . You will miss medicine. . . ."[173] She expressed fear that she would become resistant to her HIV medication when the nurses refused to replenish her supply after she missed one appointment.[174] Many HIV medications must be taken consistently and regularly; otherwise, the patient risks developing immunity to the drug. Women participating in a 2006 study conducted by the International Community of Women Living with HIV/AIDS expressed the sentiment that health care providers at government hospitals deliberately delayed the distribution of ARVs to patients.[175] Moreover, these women distrusted the ability of government facilities to provide treatment to those in need.[176] In general, women reported that they received superior care at private hospitals, in comparison to public facilities, in terms of ARV treatment and counselling.[177] (See Inadequate Service Provision section.)

Many service providers who operate existing centres are not adequately trained in the appropriate methods of administering ARV or PMTCT treatment.[178] Allan A. Maleche, a lawyer from KELIN, explained that when the government pledged free ARV treatment to those in need, it did not consider the capacity of health care facilities to provide these services.[179] The government failed to factor in the amount of personnel required to deliver a certain service.[180] For example, a district hospital providing ARVs may have only one physician who is trained in this area.[181]

Government facilities in particular suffer from a lack of trained staff to provide ARVs. The 2004 KSPAS found that NGO and private facilities most commonly provide ARV services.[182] According to Maleche, the Ministry of Health and the Ministry of Finance have not allocated adequate funds to employ the necessary personnel to provide ARV treatment.[183] Furthermore, remuneration for trained health care providers who can provide ARV services is superior at private hospitals. Many health care providers may therefore choose to seek employment at private facilities. The lack of trained staff at public facilities is a significant barrier to quality health care for Kenyans who cannot afford private facilities;[184] this problem particularly affects women, who may have to depend on their spouses and relatives for the fees to access these services.

Comprehensive Care Centres (CCCs), which provide integrated antenatal care and HIV treatment to women, also suffer from a lack of trained professionals. Most CCCs are located at district hospitals and do not employ sufficient personnel,[185] which can be a disincentive for women who seek treatment.[186] *Failure to Deliver* documented the deterrents to accessing health care that are posed by long waits at health care facilities.[187] When women travel to CCCs and encounter a long queue for health care services, they may be discouraged and decide to forego treatment.[188]

At the level of distribution, the NASCOP official stated that an inadequate number of ARV centres exist to address the demand for ARVs. In 2006, 303 ARV administration sites existed throughout Kenya, compared to 859 sites established for voluntary counselling and testing for HIV,[189] and more than 700 sites that offered PMTCT services.[190] A major problem with the limited number of ARV centres is that many patients lack access to viable transportation to the facilities, to which they must frequently return for new supplies and monitoring.[191] Just as *Failure to Deliver* documented the barriers posed by additional costs when women seek contraceptive services,[192] the same is true of ARVs. When a woman faces added fees associated with ARV treatment, such as transportation, and she does not have the financial resources to cover these costs independently, she must often turn to her partner for financial assistance. If the partner opposes the woman's decision to use ARVs, his denial of funds can prevent her from accessing the appropriate treatment. The Kenyan government, in partnership with NASCOP, is planning to increase the existing ARV infrastructure in Kenya through the decentralization of ARV treatment centres. According to the NASCOP official, 70 satellite sites have been opened, which has increased the uptake levels in ARV treatment.[193]

The scarcity in supply of ARV drugs is another major challenge in access to treatment. The NASCOP official who spoke with FIDA Kenya/CRR explained that Kenya is experiencing a shortage of ARV drugs at the national level, which results from a lack of funding for purchasing an adequate quantity of the necessary medication.[194] According to the 2004 KSPAS, ARV care and support services were "available in less than 30 percent of facilities nationally."[195] Moreover, approximately 40% of government- or NGO-managed facilities that offer ARV services had experienced stockouts of at least one type of ARV in the six months preceding the publication of the 2004 KSPAS.[196] The government, partners, and donors supply the funding for ARVs. Donors have provided 50% of the available medication, with partners and the government financing the purchase of the remaining medication. However, the budgetary allocation for purchasing ARVs falls short of the demand. Yet this official explained that purchasing an adequate supply of ARVs for Kenyans who require treatment should not be a particularly demanding expenditure for the government as ARV treatment costs approximately $10 to $15 per month per patient, for a total price of $120 per patient per year.[197]

Inappropriate or Unaffordable Fees

Much as many women documented in *Failure to Deliver* faced supplementary fees when seeking health care services that should be free,[198] women living with HIV reported that they had to pay unanticipated fees associated with free HIV treatment.[199] Although government hospitals provide ARV treatment free of charge, patients must pay an enrolment fee of Kshs. 100 (USD 1.50) in order to participate in the programme.[200] Certain facilities do not impose such charges. For instance, "treatment is . . . provided completely free of charge by a number of the President's Emergency Plan for AIDS Relief (PEPFAR) funded programmes throughout the country, though enrolment in these programmes is now difficult as many of them are full."[201] Many private facilities have also committed to providing free ARV treatment.

KENYAN WOMEN ARE OFTEN UNABLE TO ACCESS HIV TREATMENT *because they cannot afford the fees that accompany otherwise-free services.*

The NASCOP official confirmed that although ARV treatment is free, patients must pay for the costs of certain tests, which are necessary to commence a treatment regime.[202] Such charges include "pay[ing] for a CD4 count, a full haemogram and a liver function test,"[203] as well as a consultation fee, lab fees, and any costs associated with testing for and treatment of opportunistic infections, with the exception of tuberculosis.[204] The government provides free access to ARV medication alone. While the PEPFAR-funded programme covers all of the costs associated with accessing HIV treatment, this programme is largely unavailable to most Kenyans because it is filled to capacity.[205]

The consultation costs for beginning a government-initiated ARV programme vary from region to region. In the villages, the NASCOP official maintained that consultations were largely provided free of charge, but at district hospitals, the consultation fee could be as much as Kshs. 500 (USD 8). This official also referred to a government policy that instructs all health centres to provide consultation services at a fee of Kshs. 20 (USD 0.30), while dispensaries should charge Kshs. 10 (USD 0.15) for a consultation.[206]

Kenyan women are often unable to access HIV treatment because they cannot afford the fees that accompany otherwise-free services.[207] For many women, the enrolment fee of Kshs. 100 (USD 1.50) for HIV treatment is a prohibitive sum that prevents them from obtaining appropriate treatment.[208] Jo, a community health worker at New Nyanza Provincial hospital, informally known as Russia, explained that women looking to access HIV patient support had been turned away; they were told to search for money for the tests that they were unable to afford.[209] She recounted the story of an older woman who "was sent away" from Russia because she could not afford the tests required to begin treatment, which cost approximately Kshs. 6,000 (USD 92).[210] Jo concluded that "the government hospitals should know that people who are HIV positive, some of them cannot afford even Kshs. 1,000 (USD 15), which they are paying."[211]

Catherine explained that a patient's financial status would often determine her access to quality treatment. She recounted, "When nurses call for doctors, [the doctors] ask how the people look: if they have money or not. When [the doctors] are told that [the patients] look moneyed they come so quickly. We can't complain because we don't have money to go further."[212]

The NASCOP official mentioned that patients who are unable to pay the costs associated with HIV treatment could access the cost-waiver system that exists for government facilities, which is discussed in *Failure to Deliver*.[213] However, despite this official's assurances that most patients who require a cost waiver are able to acquire it,[214] *Failure to Deliver* documented that the process of obtaining this waiver can be burdensome, demeaning, and dangerous for the health of the client.[215]

Thus, although government policies require that women have access to free ARVs, some women continue to face excessive costs, which pose a tremendous barrier to quality care. According to one study, which mapped the experiences of HIV-positive Kenyans with obtaining medical care and support,

> *[p]overty is the main barrier to accessing treatment in Kenya. Raising as little as Kshs. 100 (1.3 USD) was difficult for most people since most of them survive on an income of less than a dollar (Kshs. 78) a day. . . . Poverty also means that people experience difficulty in paying for transport to get to services, especially when traveling from rural areas where distances to the nearest clinic or hospital are further and infrastructure poorer. People residing in slum areas of Nairobi and rural areas experienced the greatest difficulties in accessing treatment.*[216]

These costs particularly affect women because the prevalence of HIV is higher among women; thus, women require HIV-treatment services in greater magnitude than men. At the same time, poverty has a more profound impact on women.[217] As a result of the confluence of these two factors, women living with HIV—the segment of the population that is most in need of HIV treatment—may face the greatest barriers to accessing it.

Additionally, for women who anticipate free services, the lack of clarity regarding the fee structure for tests associated with HIV treatment may also pose an obstacle. Many of the officials interviewed were uncertain as to the exact costs accompanying the provision of ARVs, even when the officials spoke on behalf of the ministries that were responsible for determining the payment structure for these services. For example, an official at NCAPD was unsure of the costs of testing that accompany accessing free ARVs.[218] Similarly, an official at NACC lacked clear knowledge about the fee structure associated with opportunistic infections.[219] The widespread confusion about such fees poses an additional barrier to women who seek these services.

Inadequate Service Provision

As documented in *Failure to Deliver*, Kenyan women consistently reported that lack of medical attention was a significant challenge when they delivered their children at health care facilities.[220] This problem has health implications for all women, with specific repercussions for those living with HIV. According to UNFPA and WHO,

> *[t]he skilled attendant is at the centre of a successful continuum of care throughout pregnancy and after delivery, which also requires a well-functioning health care system. In addition to the components of care provided for all women, skilled care for women living with HIV/AIDS includes considering the effects of HIV/AIDS on complications during pregnancy, childbirth and postpartum; paying attention to their HIV-related treatment and care needs; and intervening to reduce HIV transmission to infants.*[221]

Therefore, a properly operating health care system is necessary to address the special needs of HIV-positive women who seek medical care, particularly during delivery.

Lack of Medical Attention/Inattentive Staff

In the absence of a well-functioning health care system, women with HIV/AIDS are particularly vulnerable when they seek heath services, as HIV-positive pregnant women require strengthened and modified obstetric and medical care.[222] "A deteriorating health care system both limits access to . . . HIV/AIDS services and compromises the quality of those services."[223] UNFPA and WHO recommend that "[w]omen living with HIV/AIDS should be advised to deliver with a skilled attendant, preferably in a health facility that can provide antiretroviral drugs for prophylaxis of mother-to-child transmission. . . . Care during childbirth needs to be modified to reduce the risk of mother-to-child transmission."[224]

However, women and service providers interviewed by FIDA Kenya/CRR discussed the lack of specialised care for HIV-positive women. Jennifer, a health care provider, recounted her own experiences with these shortcomings:

> *[A]t the maternity they say that the woman with HIV should give birth in a maternity hospital so that the child is not affected with HIV. But you see the services are just normal and the child is delivered the normal way. The mother does not get the benefit. . . . The government said [HIV-positive] women should not be in delivery for long. [However,] the woman will not be checked especially if they [see on her card that the woman is] HIV [positive]. [The woman] will be in labour for long and the blood will mix. The obstetrics services to ensure no transmission [are] not followed and there is that "don't care" attitude. And I don't know what can be done to ensure the woman gets proper services. Because many times it is the trainees [providing care] who maybe do not have the keenness to see the woman gets the services.*[225]

*"**IN THE LABOUR WARD** there is a lot of circus and if this is not rectified, the children born to HIV positive mothers will not turn out to be negative."*

Such behaviour is a clear violation of the instructions in the PMTCT Guidelines which emphasise that:

> *Emotional support during labour is important for all women, and may be [even] more necessary for an HIV positive woman who is concerned about her condition and the risk of transmission to the child . . . labour ward staff must be sensitive to the fears and concerns of the HIV positive mother. . . .*[226]

The PMTCT Guidelines also caution that "[i]mmediately after birth, [the] baby should be washed with warm chlorhexidine solution or wiped dry with a towel or surgical cloth to remove maternal bodily fluids."[227] However, one woman explained that after her daughter, who is HIV-positive, gave birth to a baby at New Nyanza Provincial Hospital (informally known as Russia) in 2006, the nurses did not immediately clean the blood off of the child:

> *[The nurse] knew [my daughter] was HIV positive. [My daughter] was so mistreated that after delivering she was told to lie on the bed for one hour, without being stitched and not knowing where her child was. I saw her in the evening. I observed that if the child was not cleaned [of] the blood, the child would become HIV-positive just like the mother and yet they were supposed to save the baby. This was not good . . . in the labour ward there is a lot of circus and if this is not rectified, the children born to HIV positive mothers will not turn out to be negative.*[228]

Other measures to prevent transmission called for in the PMTCT Guidelines are also lacking. The Kenyan Government has adopted the policy of administering Nevirapine, an antiretroviral drug, to pregnant women for free.[229] The administration of Nevirapine to the pregnant woman during delivery, and to the child shortly after birth decreases the risk of HIV transmission to the child.[230] However, according to the 2004 KSPAS, antiretroviral prophylaxis for PMTCT is only offered in 58% of facilities that provide PMTCT services.[231] (See Barriers to HIV/AIDS Treatment section.)

Lack of Equipment, Supplies, Infrastructure, and Hygienic Conditions

The PMTCT Guidelines recognise that for optimal obstetric practice, a health care facility must "[p]rovide a safe delivery infrastructure with a water source, good drainage electricity, delivery beds covered with a waterproof material, antiseptics, gloves, and other materials required for a hygienic delivery environment."[232] However, *Failure to Deliver* chronicled the reality that Kenya's health care system suffers from a dearth of such supplies, which prevents women from receiving quality maternal health services.[233] The lack of adequate health care supplies and infrastructure, coupled with chronic understaffing, creates unhygienic conditions that pose dramatic threats to the lives and health of mothers and their babies.[234] Moreover, the unsanitary environment at Kenyan health care facilities has serious ramifications for women living with HIV, who require greater attention in the provision of health care, and increases the risk of infection for women in general.

As a result of the limited resources and facilities at many hospitals, women reported being forced to share beds and supplies with other women in overcrowded maternity wards. Leah, who delivered at Russia in December of 2006, recounted, "I was told to go to the ward. There were three people in one bed. . . ." [235] Former Pumwani Maternity Hospital matron Evelyn Mutio explained the danger of using the same bed for multiple deliveries: "There's doubling of patients in one bed because facilities are few. . . . With delivery and the blood, with HIV, you can't have people sharing a bed."[236] Sharing

beds could also increase the risk of HIV-positive women contracting opportunistic infections from other patients, further jeopardising their health.

Many of the women whom FIDA Kenya/CRR interviewed explained that the hospitals in which they delivered their children lacked basic supplies, which they expected the patients to provide. Leah, a woman who delivered her baby at Russia in December of 2006, related:

> *I gave birth at 3 p.m. and was stitched at 4 p.m. I was just waiting. The baby was crying. I later learned that the stitching equipment was not there and [that] is what they were looking for. I was not told. . . . I was left there. Later they came and I had bled. [I] was in pain. The baby was cold. . . . There was no water. I had to get water from home. . . . There was no proper hygiene. I left after three days. My experience was not good. . . . The baby was just covered with a lesso [wrapper]. . . . The baby had not been cleaned. I am the one who cleaned the baby with cold water. You had to buy cotton and if you don't have [any] they quarrel [with] you. Pads also you must have.*[237]

The lack of the materials and supplies required for the administration of proper medical treatment creates a significant obstacle to the provision of adequate health care services. Without sufficient supplies, such as latex gloves and water for cleaning, health care providers cannot take universal precautions to protect themselves and others against the transmission of HIV. According to the 2005 Kenya Health Workers Survey, only 57% of health care workers reported that the health care facilities in which they work had an adequate supply of running water.[238] The same survey revealed that "most providers feel at great risk of occupational HIV infection because they lack adequate supplies of basic infection control items such as water and soap."[239]

These shortages in supplies can result in the refusal of health care professionals to provide medical treatment to HIV-positive patients. According to Maleche, a lawyer at KELIN, medical professionals may be afraid of procedures that involve contact with HIV-positive patients, particularly in the absence of adequate protective gear.[240] Maleche confirmed that many hospitals experience shortages of post-exposure prophylaxis and gloves, particularly hospitals that are located in remote areas. According to the 2004 KSPAS, only 8% of all surveyed facilities[241] provide the staff with access to post-exposure prophylaxis (PEP).[242] The 2005 Kenya Health Workers Survey reported that "42 percent of health workers say PEP is available in their facility or somewhere else nearby … this suggests that the majority of health workers, nearly 60 percent, do not feel they have access."[243] In addition to an insufficient supply of PEP, health care providers also report inadequate training about the use of post-exposure prophylaxis and reluctance to use this medication. The 2005 Kenya Health Workers Survey reported that, "only half of providers can be said to have functional knowledge about PEP (i.e., have heard of it and can accurately describe it) … About two thirds who did not seek PEP said it was because of lack of sufficient information (40 percent) and fear of the process (28 percent)."[244] The inadequate access to and lack of information about post-exposure prophylaxis is most likely a contributing factor to the reluctance of health care providers to treat HIV positive patients, because they fear contracting this illness. (See Violations Around Testing section.)

***THE LACK OF ADEQUATE HEALTH CARE SUPPLIES AND INFRASTRUCTURE**, coupled with chronic understaffing, creates unhygienic conditions that pose dramatic threats to the lives and health of mothers and their babies.*

Insufficient equipment, supplies, and infrastructure at some Kenyan hospitals may expose women who are not HIV-positive to the possibility of contracting the virus. In *Failure to Deliver,* former

Pumwani Maternity Hospital matron Evelyn Mutio explained how these shortages lead to unhygienic conditions: "The hospitals need supplies, equipment, and tools. . . . If you have five babies coming, how do you sterilize the forceps?"[245]

Jackline believes that she contracted HIV during her 2002 delivery at Madiany hospital in Uyoma Bondo, when a nurse used a pair of scissors to cut one patient and then immediately used the same pair to cut Jackline.[246] Jackline received an HIV test the year following her delivery, and when she tested positive while her husband tested negative, she traced her contraction of the virus to her delivery. She recounts: "[a]fter the test I was positive and he was negative. I later started thinking about where I could have gotten the virus and I flashed back to the time I gave birth …"[247]

Discrimination Against Women with HIV and AIDS

Women in general often experience mistreatment and harassment in seeking delivery services in Kenyan health facilities.[248] This abuse can be exacerbated for women who are HIV positive. Women living with HIV/AIDS often confront biases and negative attitudes from health care providers, particularly regarding their sexual and reproductive health practices, although discrimination against persons living with HIV is prohibited by law.[249] The HIV and AIDS Prevention and Control Act [HIV Act] mandates that "[e]very health institution, whether public or private, and every health management organisation or medical insurance provider shall facilitate access to healthcare services to persons with HIV without discrimination on the basis of HIV status."[250] However, women living with HIV experience discrimination at many levels. They are reprimanded for bearing children, frequently turned away from public-health facilities, and referred to private hospitals specialising in HIV care, where costs are usually higher.[251] HIV-positive women also confront cultural stigma regarding their HIV status, and risk domestic violence and abandonment by their partners. The stigma and discrimination encountered by HIV-positive women has an impact on the kind of care they receive and on the decisions they make about disclosing their status or seeking care.

Stigma and Discrimination in the Health Care Setting

In a discussion with FIDA Kenya/CRR, Enid described the harassment and denial of HIV treatment that many women experience at New Nyanza Provincial Hospital, informally known as Russia, because of their HIV status.[252] She explained that when the nurses at this hospital realise that a patient has been referred from Family AIDS Care and Educational Services (FACES), an HIV/AIDS treatment and care programme, they are told to return to that organisation to receive their medication: "When one goes [to Russia] with a referral from FACES and they see that the referral is from FACES, they say that we people from FACES are crowding the wards with patients who are HIV positive."[253] Similarly, Enid stated that nurses will ask, "[W]hy don't you take the patient to FACES so that he/she may be administered drugs by there?"[254]

Other women confirmed that nurses at Kenyan medical facilities are reluctant to provide proper health care to HIV-positive women. According to Judy, who discussed conditions at the Provincial Hospital, "[i]f you go to the Provincial, to be assisted by a person to deliver, you see that you are not getting your rights, you are not treated well especially if you are HIV positive. You know HIV, they see [it as if] AIDS does not have a cure and one will die, so we are left helpless."[255] Yet the HIV Act requires that "[n]o person shall be denied access to healthcare services in any health institution, or be charged a higher fee for any such services, on the grounds only of the person's actual, perceived or supposed HIV status."[256] Furthermore, according to the PMTCT Guidelines, "Women with HIV should not be isolated or treated differently from other women in labour."[257] However, the 2005 Kenya Health Workers Survey indicates that "[o]ne in ten providers, including 15 percent of medical doctors, felt that health workers should 'have the right to refuse to care for AIDS patients.'"[258]

*"**IF YOU GO TO THE PROVINCIAL**, to be assisted by a person to deliver, you see that you are not getting your rights, you are not treated well especially if you are HIV positive."*

A counsellor at Women Fighting AIDS in Kenya (WOFAK) recounted the story of an HIV-positive pregnant woman who was receiving HIV treatment at the facility. Because WOFAK does not provide

*"**ONE IN TEN PROVIDERS**, including 15 percent of medical doctors, felt that health workers should 'have the right to refuse to care for AIDS patients.'"*

PMTCT services, she sought antenatal services at a public hospital. When service providers at the hospital demanded that this woman undergo an HIV test, she informed them of her HIV-positive status and informed them that she was receiving ARVs from WOFAK. The service providers responded by refusing to continue treating the woman, telling her to return to WOFAK.[259]

Jennifer explained that when health care workers learn that a patient is HIV positive during delivery, they often neglect that patient: "The woman will not be checked especially if they check the [patient's record] and see you are HIV [positive]."[260] Allan A. Maleche, a lawyer at KELIN confirmed that medical professionals sometimes discriminate against patients living with HIV by secluding them in a specific area of the hospital and using derogatory terms when speaking to them.[261]

Maleche also expressed concern that health care providers, fearing the spread of HIV between positive and negative patients, could deny proper care to HIV-positive patients.[262] For example, he reported that health care providers may not allow patients who are HIV positive to use the dialysis machine because they fear that this usage could transmit the virus to other patients.[263]

Negative Views of HIV-Positive Women's Sexuality and Motherhood

Women living with HIV in Kenya may also confront discrimination in accessing family planning and maternity services. Health care providers who offer family planning services may be ill-informed about the issues surrounding HIV.[264] According to Maleche, many Kenyans assume that a woman who is living with HIV should not be sexually active.[265] Maleche explained that when an HIV-positive woman goes to a family planning centre and asks for contraception, counsellors may be reluctant to discuss contraceptive options with women who are living with HIV and may even refuse to dispense them.[266]

The discrimination that HIV-positive women experience may increase their risks of transmitting the virus to their partners or unintentionally conceiving. For example, ARVs may make certain contraceptive methods less effective; therefore, dual-barrier methods of contraception are often recommended for women living with HIV.[267] Additionally, the highest rate of HIV infection occurs through sexual intercourse. Therefore, women must be advised and counselled about safety precautions when engaging in sexual intercourse in order to prevent the transmission of HIV or reinfection with the virus, as well as the appropriate use of contraceptives and their possible interaction with ARVs. According to the ART Guidelines, "HIV infected women may choose to engage in unprotected sexual intercourse for purposes of pregnancy. [Health care workers] should be proactive in discussing [a] patient's reproductive concerns to enable risk reduction behaviour to be adopted."[268]

Negative views of HIV-positive women's sexual activity also have implications for how some health care workers address pregnancy among HIV-positive women. According to one study that assesses family planning needs in Kenya in the context of the HIV/AIDS epidemic, "A considerable number of service providers said that pregnancy ought to be prevented at all cost in HIV-infected women. They rarely discuss the relative risk of infection to the baby and how PMTCT interventions can reduce that risk."[269] Women with whom FIDA Kenya/CRR spoke also described the discrimination they experienced at hospitals during antenatal treatment and delivery. Diana, an HIV-positive woman who gave birth at Russia, described visiting the hospital to receive antenatal treatment: "the nurses reprimanded me and harshly asked me why I had conceived and I knew of my HIV status. I felt very bad."[270] Sarah, who delivered in a district hospital, recounted, "nurses . . . usually say that since one knows [she is] HIV positive, [she] should not give birth. What we are asking . . . don't positive

people need children? It is not someone's fault. Imagine being HIV positive at 28 years and you need children. It is one's right and why should you be scared and not allowed to give birth?"[271]

A doctor who works at Kenyatta National Hospital confirmed that some health care providers maintain the view that HIV-positive women should not have children.[272] He also noted that Kenyatta's health care providers had previously counselled HIV-positive women against receiving treatment for infertility in an attempt to ensure that they did not become pregnant.

The attitude exhibited by health care providers who refuse to provide adequate treatment to women living with HIV, criticise them for their choice to have children, and subject them to permanent sterilisation methods is a violation of the patients' rights to health and to found a family.

Social and Cultural Barriers to Accessing Health Care

Stigma

Women in Kenya also confront social and cultural barriers to accessing HIV treatment and health care services, in the form of stigma. According to a report written by the Open Society Institute (OSI), which documents the impact of HIV on vulnerable groups in Kenya, "many women do not take HIV tests in order to avoid the negative repercussions of AIDS stigmatization for themselves and their children, thus denying themselves critical information about their health."[273]

Maleche, the KELIN lawyer, described the stigma that many HIV-positive women may face when accessing HIV treatment, particularly if these women depend solely on their husbands for support.[274] When a woman becomes pregnant and seeks services at an antenatal clinic, she may also receive an HIV test. If the test indicates a sero-positive status, the woman should be advised about the precautions she should take to prevent transmitting HIV to her child, such as ARV treatment, having a Caesarean section, and the possibility of feeding her baby with formula, rather than breast milk. A woman in this situation may need to secure consent from her husband to receive HIV treatment and to explore alternate feeding practices, Maleche explained. However, the "husband may not agree to the child taking ARVs and being formula fed because of the big issue of stigma."[275] According to Maleche, the husband may want to avoid questions from the community about why his family is behaving differently from the other families, and why his wife is not breastfeeding the children. In order to avoid the "issue of stigma and likelihood of discrimination," the husband may hinder access to proper HIV treatment for his wife and child.[276]

Maleche also addressed the situation of Kenyan women who may not totally depend on their husbands, and are knowledgeable about their rights, but nevertheless encounter stigma and discrimination because of their HIV-positive status, which prevents them from accessing appropriate medical treatment. According to Maleche, these women may be more willing to defy the wishes of their husbands by receiving ARV treatment and using formula. However, such couples may experience friction within their marriage as a result of the woman's decisions, which could lead to a breakdown of the marital relationship and ultimately end in divorce. In Kenyan society, divorced women are often perceived negatively and are subject to discrimination. Additionally, Maleche summarised, "[women] will decide to follow the cultural perspective for the sake of not looking the odd one out."[277] These discriminatory views can therefore compel women to forego HIV treatment if their husbands or communities place a strong emphasis on cultural conformity.[278]

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*"**ISSUES OF POWER AND INEQUITY** . . . affect those women's ability to make decisions about health issues that personally affect them."*

Furthermore, even if a Kenyan woman is not economically dependent on her husband during marriage, she can often find herself in a more vulnerable and precarious situation at the dissolution of their marriage, with dire economic consequences.[279] According to the OSI report, "Kenyan women traditionally gain access to property through their male relatives. When these relationships end through divorce or the death of a spouse, women face the prospect of abandonment and destitution."[280] As the result of the potential financial vulnerability of single women in Kenyan society, women living with HIV may choose to forego HIV treatment in order to preserve their marriages and financial security.[281]

According to Maleche, "issues of power and inequity . . . affect those women's ability to make decisions about health issues that personally affect them. . . . [The husband] presumes he has the sole right over the lady and to make decisions about that lady's issues."[282] Maleche explained that Kenyan society must work to address such discrepancies in power between men and women, both within marriage and within the community in general.[283] He emphasised that men must understand that women have the right to control their bodies, particularly from a health perspective.[284]

An official from NACC also noted the challenges that stigma presents to receiving appropriate HIV treatment.[285] He explained that stigma can often lead to the breakdown of families and recommended an increase in advocacy efforts targeted at programmes to reduce stigma, thereby ensuring that women can access appropriate HIV treatment.[286]

Domestic Violence and Abandonment

The risk for women of domestic violence and abandonment when their partners learn they are HIV-positive has serious implications on how they approach HIV testing, disclosure of their status, and whether to seek treatment.

Even the act of taking an HIV test can subject women to domestic abuse from their partners. According to a human rights advocate in this field, "[e]xperience has shown that, in some situations, women who have undergone HIV testing often face adverse consequences which may include . . . a violent reaction from their husbands."[287] OSI's report on the impact of AIDS on vulnerable communities in Kenya also concludes that many women avoid disclosing their HIV status to their partners for fear of violence.[288] According to this report, the general secretary of the Christian Health Association of Kenya (CHAK), the umbrella organisation for non-Catholic, Christian faith-based health facilities, reported that CHAK "frequently encountered cases of women who had been beaten by their husbands upon disclosure of their HIV status."[289] In addition, "CHAK had seen numerous cases of women reporting abuses such as . . . domestic violence. In many cases, husbands and their extended families perpetrated such abuse after learning or suspecting the woman's HIV status."[290]

Some women explained that they were afraid to inform their partners of their HIV sero-status because of the risk of destroying their relationships. Liz recounted her experience of telling her husband that she was HIV positive, which contributed to the collapse of her marriage despite strong indications that her husband had infected her after inheriting another man's wife[291]:

> *I got to know of my status [in] 2004. . . . One time people from CDC [the Center for Disease Control] came to my village and they talked of VCT encouraging all to take the test, I did and tested positive. When I told my husband, he didn't want to listen. He*

blamed me for the virus, telling me that [I] am the one who brought it. I discovered that he knew [his] status and [the status of] the other woman and they would go for ARVs without telling me. I went to the health centre where I was given Septrin, and they counselled me. One of the teachers called me and took me to Nyalenda [a small town] where I sat with other women who shared with [me] all their experience. They advised me not to bother my husband and start a business to avoid conflict, they told me to stay like a woman whose husband died. When I went back home, I started talking to other women who were HIV positive in the village. We opened a women's group. . . .[292]

Catherine, a woman who discovered that she was HIV positive, described the difficulty she experienced when she informed her husband of her sero-status:

[M]y husband was ailing, I decided to go and test. . . . I tested positive but I didn't tell my husband who was in and out of hospital. When I later told my husband, he was angry, quarrelling [with] me and blaming me. I went to my father-in-law and I asked him to talk to [my husband], telling him of my status. [My husband] denied [the request]; I just left him. . . . [In] 2006, he was admitted at the general hospital and he was very angry when I came back. He nearly hit me with a stool. I gently took it away from him and took it outside the house. I cried a lot on that day till I decided . . . that it wasn't helping. I talked to the counsellor/sister who is positive and she agreed to talk to him. He agreed and was started on ARV[s]. . . . I also started taking ARV[s].[293]

Similarly, Sarah discussed her fear that if she informed her husband that she was living with HIV, he would become violent towards her and would refuse to acknowledge the reality of her status and the fact that he was also HIV positive:

I could not tell my husband I was positive because if I told him, he would have said I was the one who infected him and we would start fighting. I did not know how to tell him so I decided to handle it alone. . . . He thought I had become ill, I would not recover. When I was in the ward, the nurses would call him but he was very difficult, he did not listen to the advice. I refused to discuss with him because he would become violent towards me at home. He knew that he died of HIV. . . .[294]

Jane, who tested positive for HIV at a small maternity hospital, stated:

[W]hen I came [to Kasarani], I was tested. . . . I was told I was positive. . . . I haven't told my husband. . . . [The nurses] keep on insisting that I tell my husband. I have told them that I can't tell him. . . . I'm comfortable here because they know my status. [If I have to go to another facility] I am worried about the treatment I and my baby will receive and also they would want to involve my husband.[295]

Jane's explanation illustrates the apprehension that some women feel about revealing their HIV status. This fear can serve as a barrier to health care for women like Jane, who dread attending health care facilities lest the health care providers reveal their HIV status to their partners.

*"**THE TEACHERS ADVISED ME NOT TO BOTHER MY HUSBAND** and start a business to avoid conflict, they told me to stay like a woman whose husband died. When I went back home, I started talking to other women who were HIV positive in the village. We opened a women's group."*

SUCH EXPOSURE TO DOMESTIC VIOLENCE *and fear of abandonment present tremendous obstacles to many women, who may forego HIV treatment and care services in order to refrain from drawing attention to their illness.*

The subordinate status of many women in Kenyan society, particularly in their access to property rights, which is a determinate of economic stability and independence, often leaves them dependent on their partners and therefore vulnerable to abuse. This situation is particularly aggravated in the context of HIV; Kenyan women living with HIV may experience domestic violence at the hands of their partners upon the revelation of their sero-status, which forms part of the stigma and discrimination that frequently accompanies this virus. Such exposure to domestic violence and fear of abandonment present tremendous obstacles to many women, who may forego HIV treatment and care services in order to refrain from drawing attention to their illness and confronting a situation in which they must reveal their sero-status to their partners. The failure of the Kenyan government to ensure that these women are not subjected to domestic abuse because of their sero-status constitutes an egregious human rights violation.

The Human Rights Implications of Violations in the Context of HIV

The negligence and abuse documented in this report have more than just public health implications; they also constitute serious violations of human rights that are protected under national, regional, and international law. Fundamental rights that the government of Kenya is obligated to guarantee include the rights to equality and non-discrimination, the right to privacy, the right to found a family, the right to the highest attainable standard of physical and mental health, the right to dignity, and the right to information. The violations described in this report demonstrate that Kenya is not honouring its domestic and global commitments to respect, protect, and fulfil these rights.

International and Regional Standards

Several regional treaties—the African Charter on Human and People's Rights (African Charter),[296] the African Charter on the Rights and Welfare of the Child (African Charter on Children),[297] and the African Charter's Protocol on the Rights of Women in Africa (Maputo Protocol)[298]—provide important protections for the rights of women and girls in Kenya. The Kenyan government has ratified the African Charter and the African Charter on Children, and has signed but not yet ratified the Maputo Protocol.[299] However, even by signing the Maputo Protocol, which offers the most explicit recognition and protection of reproductive rights in the African regional system, Kenya is obligated to refrain from acting in a way that "would defeat the object and purpose of the treaty,"[300] which includes "the full realisation of the rights" recognised in the treaty.[301]

Kenya has also confirmed its commitment to upholding international human rights standards by ratifying several major global treaties, including the International Covenant on Civil and Political Rights (Civil and Political Rights Covenant),[302] the International Covenant on Economic, Social and Cultural Rights (Economic, Social and Cultural Rights Covenant),[303] the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW),[304] the Convention on the Rights of the Child (Children's Rights Convention),[305] and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Convention against Torture).[306] A state that ratifies or accedes to an international convention "establishes on the international plane its consent to be bound by a treaty."[307] The government of Kenya is therefore obligated under international law to protect the rights guaranteed by these instruments. However, with the exception of the Children's Rights Convention, Kenya has failed to domesticate the provisions of these treaties through national-level laws. Furthermore, Kenya has not yet ratified the Optional Protocols to the Civil and Political Rights Covenant, CEDAW, or the Convention against Torture—all of which would permit individuals to submit rights-violation claims directly to the relevant monitoring body, as established by each treaty, after exhausting domestic remedies.

In addition to the politically binding international consensus documents that support the reproductive rights framework, similar politically binding statements, international agreements, and standards exist to support the HIV/AIDS framework.[308]

THE VIOLATIONS DESCRIBED IN THIS REPORT *demonstrate that Kenya is not honouring its domestic and global commitments to respect, protect, and fulfil these rights.*

Protected Rights

The government of Kenya is legally bound to respect, protect, and fulfil the following rights pursuant to the international and regional conventions that it has signed or ratified. Particularly in the absence of a comprehensive legal framework regarding HIV/AIDS, Kenya must rely on the international human rights standards that have been developed around this issue.

The right to health

International and regional treaties and covenants repeatedly recognise the fundamental right to the highest attainable standard of mental and physical health, and impose an obligation on states to enforce this right.[309] The right to health is not confined to the right to health care, but includes freedom from interference with one's health, the right to control one's health and body, and the right to access essential health information.[310] A state's principal obligation in respect to the right to health under the Economic, Social and Cultural Rights Covenant is to take steps "with a view to achieving progressively the full realisation of the rights recognised" in the covenant.[311] The concept of progressive realisation constitutes recognition of the fact that while full realisation of all economic, social, and cultural rights may not be feasible in a short period of time, each state nonetheless has an obligation to move as expeditiously and effectively as possible towards the realisation of these rights, "to the maximum of its available resources."[312]

The Committee on Economic, Social and Cultural Rights (ESCR Committee), in its General Comment on the right to the highest attainable standard of health (General Comment on Health), maintains that the essential components of the right to health are "availability, accessibility, acceptability, and quality of health facilities, goods and services."[313] The principle of accessibility requires that states ensure that medical services are "within safe physical reach for all segments of the population, especially . . . women . . . and persons with HIV/AIDS."[314]

Additionally, a woman's right to health is violated when she cannot access health care services because of her financial status. The ESCR Committee has elaborated that "[e]quity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households."[315] Similarly, the International Guidelines provide that "[s]tates should increase their national budget allocations for measures promoting secure and sustainable access to affordable HIV . . . treatment."[316] The refusal to treat women or provide them with access to ARVs because they cannot afford fees associated with this treatment regime violates their right to health.

The neglect that women—particularly those who are living with HIV—experience in Kenyan health facilities is yet another serious violation of the right to health. The ESCR Committee has called on states "to ensure the appropriate training of doctors and other medical personnel, [and] the provision of a sufficient number of hospitals, clinics and other health-related facilities. . . ."[317] The lives and health of Kenyan women and children are threatened by the inadequate provision of medical services, unhygienic delivery conditions without safeguards against opportunistic infections and transmission of HIV, lack of access to ARV treatment centres and limited supplies of ARVs, and the shortage of basic supplies. The trauma of these negative experiences can also discourage women from seeking reproductive health care services in the future and cause them to turn to traditional birth attendants[318] who cannot provide appropriate care in many instances to prevent the transmission of HIV.

The ESCR Committee has articulated that states must take specific measures for "the prevention, treatment and control of epidemic, occupational, and other diseases,"[319] such as HIV/AIDS. According to the International Guidelines, "the content of the right to health . . . now explicitly includes the availability and accessibility of HIV prevention, treatment, care and support for children and adults."[320] To this end, international and regional human rights standards require Kenya to eliminate the barriers to health care services that women living with HIV face.

The right to privacy and informed consent

The right to privacy and the right to health are closely linked in the context of HIV/AIDS. The right to privacy is protected by Article 17 of the Civil and Political Rights Covenant,[321] Article 12 of the Universal Declaration of Human Rights (Universal Declaration),[322] and Article 70 of the Kenyan Constitution.[323] The Civil and Political Rights Covenant states that "no one shall be subjected to arbitrary or unlawful interference with his privacy."[324] The Human Rights Committee has interpreted state obligations under Article 17 of the Civil and Political Rights Covenant to include a prohibition on all interferences with an individual's right to privacy by both public and private actors, to be guaranteed through the creation of legislative frameworks and other state measures that protect individual privacy.[325] In the context of HIV/AIDS, the right to privacy was explicitly recognised by the International Conference on Population and Development (ICPD), which pledged in its Programme of Action to "ensure that the individual rights and the confidentiality of persons infected with HIV are respected."[326]

According to the Economic, Social and Cultural Rights Covenant, privacy is an integral component of the right to health.[327] The General Comment on Health also maintains that the freedoms encompassed by the right to health include "the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from . . . non-consensual medical treatment. . . ."[328] The International Guidelines recognise that "the protection of the sexual and reproductive rights of women [is] . . . critical. This includes the rights of women to have control over and to decide freely and responsibly . . . on matters related to . . . sexual and reproductive health."[329] The International Guidelines urge states to enact public health legislation that ensures that "HIV testing of individuals should only be performed with the specific informed consent of that individual,"[330] and elaborate that, "whenever possible,… pre- and post-test counselling be provided in all cases."[331] They acknowledge that many HIV programmes that target pregnant women "often emphasise coercive measures directed towards the risk of transmitting HIV to the foetus, such as mandatory pre- and post-natal testing."[332] Such programmes deny women control over their bodies and "seldom empower [them] to prevent perinatal transmission by prenatal prevention education and an available choice of health services and overlook the care needs of women."[333] Rather, when women seek antenatal treatment, they "should be provided with accurate information, about the risk of perinatal transmission to support them in making voluntary, informed choices about reproduction."[334]

The Committee on the Elimination of Discrimination Against Women has also concluded that the right to privacy is an essential part of effectuating women's right to health, and has required states to ensure that "all health services . . . be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent, and choice."[335] In addition, the Civil and Political Rights Covenant and the Maputo Protocol prohibit performing medical experimentation on women in the absence of their informed consent.[336]

Protection of the right to privacy and to informed consent is an essential element of HIV/AIDS prevention and treatment programmes because it encourages people to access testing and health services. People are more likely to seek health care services when they believe that health care workers will treat their HIV status confidentially. When the right to privacy is not properly safeguarded through informed consent, voluntary testing, and confidentiality, people avoid learning their status because they fear stigma and discrimination.[337] Those who access voluntary-testing services are better able to learn about HIV prevention and receive appropriate treatment; this is important not only for individuals, but also for the protection of the community, which "has an interest in maintaining privacy so that people will feel safe and comfortable in using public health measures, such as HIV prevention and care services."[338]

The Human Rights Committee has recognised a state's obligation to protect the right of privacy against interferences from both public and private entities, including private hospitals, stating: "this right is required to be guaranteed against all such interferences and attacks whether they emanate from State authorities or from natural or legal persons. The obligations imposed by this article require the state to adopt legislative and other measures to effectuate both the prohibition against such interferences and attacks and the protection of this right."[339] The right to privacy also encompasses the right to access files concerning medical treatment and status.[340]

The International Guidelines emphasise that "[t]he individual's interest in his/her privacy is particularly compelling in the context of HIV, firstly, in view of the invasive character of a mandatory HIV test and, secondly, by reason of the stigma and discrimination attached to the loss of privacy and confidentiality if HIV status is disclosed."[341] The fact that some women in Kenya learn of their HIV status by overhearing doctors discussing it among each other is a clear violation of doctor-patient confidentiality, and of the right to privacy.

The WHO declares that "there is also growing international consensus that all patients have a fundamental right to privacy, to the confidentiality of their medical information, to consent to or to refuse treatment, and to be informed about relevant risk to them of medical procedures."[342] The right to privacy of Kenyan women living with HIV is violated when health providers do not use appropriate safeguards to secure women's informed consent before testing them for HIV and breach confidentiality guarantees by disclosing the sero-status of women to hospital staff and other patients.

The right to be free from torture and cruel, inhuman, or degrading treatment

Kenya's constitution explicitly recognises the right to be free from torture and cruel, inhuman, or degrading treatment, as do numerous international and regional conventions.[343] The definition of cruel, inhuman, or degrading treatment is not restricted to acts that cause physical pain; it also extends to medical or scientific experimentation without the free consent of the person concerned.[344] The Human Rights Committee has specifically stated that the prohibition against cruel, inhuman, or degrading treatment applies to medical institutions.[345] Subjecting pregnant women to an HIV test without their informed consent is therefore a violation of this right. Additionally, the refusal of medical professionals to provide care to women living with HIV, which generates both physical and emotional suffering, constitutes cruel, inhuman, or degrading treatment.

The Human Rights Committee also specifies it is the duty of public authorities to ensure the protection of citizens against inhuman or degrading treatment, even when persons acting without any official

authority commit these acts.[346] The inability or refusal of the Kenyan government to protect women from domestic violence in general, and particularly when they reveal their seropositive status to their partners, is a violation of this right.

The right to life, liberty, and security of person

Both the Kenyan Constitution and numerous international and regional instruments protect the right to life.[347] Barriers to care for HIV-positive women in Kenya fundamentally impede this most basic right.

The Human Rights Committee has stated that the right to life "cannot be properly understood in a restrictive manner," and should not be narrowly interpreted.[348] The fulfilment of this right requires governments to take positive measures to reduce maternal mortality and increase life expectancy, particularly in adopting methods of eliminating epidemics.[349] Such measures may include taking steps to provide access to services for HIV prevention and medical treatment. According to the International Guidelines, "[s]tates should also ensure access to adequate treatment and drugs, within the overall context of their public health policies, so that people living with HIV can live as long and as successfully as possible."[350] Therefore, the Kenyan government must actively ensure that its citizens have access to ARV treatment in order to increase their life expectancies. The lack of equipment, supplies, infrastructure, and hygienic facilities in Kenyan hospitals fails to create an environment in which the incidence of maternal mortality will decline.

Furthermore, the prevalence of domestic violence against women who are tested for HIV or seek HIV treatment is a significant barrier to care for women. The Kenyan government has a positive obligation to protect its citizens from all violations of their right to liberty and security of person, including those perpetrated by private persons.[351] The inability or refusal of the government to protect women from domestic violence in the context of HIV constitutes multiple failures to safeguard this right. For women in this situation, the knowledge that they are not protected from such violence impacts their ability to seek care.

International and regional instruments recognise the right to liberty and security of person, as well.[352] Although traditionally applied to conditions of arrest or detention, this right has been expanded over time to apply to non-custodial situations.[353] According to the High Commissioner for Human Rights, the right to liberty and security of person is now one of the rights "most relevant to HIV/AIDS."[354] The WHO has identified the right to security of person as a human right in the context of health care, such that an individual must have the option to give or refuse informed consent to a proposed medical intervention, such as HIV testing.[355] Furthermore, the International Guidelines maintain that "[r]espect for physical integrity requires that testing be voluntary and that no testing be carried out without informed consent."[356] Therefore, breaches of informed consent procedures in Kenyan health care facilities violate the individual's right to liberty and security of person.

The government of Kenya must take measures to make certain that women can exercise their right to control their health and bodies, which includes ensuring compliance with informed consent procedures for HIV testing, as well as accessing ARV treatment regimes and electing alternative infant-feeding methods, without the interference of their partners and community members, who may try to direct the outcome of these choices.

The right to dignity

Human dignity is one of the most basic foundations of human rights.[357] The Vienna Declaration and Programme of Action affirms that "all human rights derive from the dignity and worth inherent in the human person," and the International Guidelines avow that "a rights-based approach to HIV is grounded in concepts of human dignity and equality which can be found in all cultures and traditions."[358] The right to dignity is also recognised and protected by various international and regional instruments, including the Civil and Political Rights Covenant, which states that "the inherent dignity" of the human person is at the source of all other human rights.[359] The African Charter echoes this concept: "Every individual shall have the right to the respect of the dignity inherent in a human being."[360] Furthermore, the Maputo Protocol requires states to "adopt and implement appropriate measures to ensure the protection of every woman's right to respect for her dignity."[361]

In the context of HIV, violations of the right to dignity are both a contributing factor to the prevalence of the virus and a consequence of it. CEDAW has highlighted the link between the reproductive role of women, their subordinate social position, and their increased vulnerability to HIV infection.[362] In this context, the right to dignity is violated when health care providers refuse to treat women who are HIV positive and fail to provide them with contraception and appropriate family planning counselling, which would enable them to make their own reproductive choices. The stigmatisation and marginalisation of people living with HIV has been recognised as an impairment of the right to dignity. In this context, Judge Ngcobo, sitting in the South African Constitutional Court, stated:

> *Society's response to [people living with HIV] has forced many of them not to reveal their HIV status for fear of prejudice. . . . Notwithstanding the availability of compelling medical evidence as to how the disease is transmitted, the prejudices and stereotypes against HIV-positive people still persists. In view of the prevailing prejudice against HIV-positive people, any discrimination against them can, to my mind, be interpreted as a fresh instance of stigmatization, and I consider this to be an assault on their dignity.*[363]

In the medical context, the right to dignity is subject to significant threat. A violation of this right occurs when pregnant women are denied the opportunity to consent to medical procedures, such as HIV tests.

The right to found a family

The right to marry and found a family is included in the Universal Declaration of Human Rights, the Civil and Political Rights Covenant, and the Economic, Social and Cultural Rights Covenant.[364] The Civil and Political Rights Covenant states that "the family is the natural and fundamental group unit of society and is entitled to protection by society and the State" and that the "right of men and women of marriageable age to marry and to found a family shall be recognised."[365] The Human Rights Committee, which oversees compliance with the covenant, expounds upon these provisions: "The right to found a family implies, in principle, the possibility to procreate. . . . When States parties adopt family planning policies, they should be compatible with the provisions of the Covenant and should, in particular, not be discriminatory or compulsory."[366] Article 10 of the Economic, Social and Cultural Rights Covenant adds that "[t]he widest possible protection and assistance should be accorded to the family, which is the natural and fundamental group unit of society, particularly for its

establishment. . . ."[367] Furthermore, the African Charter recognises that "the family shall be the natural unit and basis of society" and "shall be protected by the State." [368] The state is responsible for eliminating all forms of discrimination against women and "the protection of the rights of the woman and the child as stipulated in international declarations and conventions."[369]

Health care providers interfere with the enjoyment of this right when they discourage women living with HIV from having children or reprimand them for doing so, and fail to supply them with the necessary information to safely plan to have a family. All women, whether or not they are HIV positive, have the right to found a family. The Kenyan government must take action to ensure that women throughout Kenya are able to exercise this right without confronting discrimination from health care providers.

The rights to non-discrimination, equal protection, and equality before the law

The principle of non-discrimination in international human rights law is enshrined in Article 2 of the Universal Declaration, the Civil and Political Rights Covenant, the Economic, Social and Cultural Rights Covenant, and the African Charter. Each of these instruments prohibits distinctions "of any kind, such as . . . sex . . . or other status."[370] The term "other status," according to the UN Commission on Human Rights, "should be interpreted to include health status, including HIV/AIDS."[371]

The UN Special Rapporteur on the Right to Health has recognised that gender-based discrimination increases women's susceptibility to HIV: "[D]iscrimination based on gender hinders women's ability to protect themselves from HIV infection and to respond to the consequences of HIV infection."[372] Similarly, a scholar in this field has noted that "[w]omen become infected with HIV and become pregnant in the larger context of women's vulnerability that continues to be driven by poverty, violence, gender-related discrimination and a host of other social, economic and cultural factors that perpetuate these conditions of disadvantage."[373] In this manner, gender-based discrimination and inequality based on HIV status are often interrelated.

The International Guidelines specifically address discrimination against women living with HIV in Guideline 5(f), and discuss measures that states should enact to combat this form of discrimination:

> *Anti-discrimination and protective laws should be enacted to reduce human rights violations against women in the context of HIV, so as to reduce vulnerability of women to infection by HIV and to the impact of HIV and AIDS. . . . Laws should also be enacted to ensure women's reproductive and sexual rights, including the right of independent access to reproductive and STD health information and services and means of contraception, . . . the right to determine [the] number and spacing of children, the right to demand safer sex practices and the right to legal protection from sexual violence, outside and inside marriage, including legal provisions for marital rape. . . .*[374]

The Maputo Protocol discusses gender-based discrimination in the context of health, as well. The Protocol requires states to enact legislation to "combat all forms of discrimination against women . . . [particularly] harmful practices which endanger the health and general well-being of women."[375] In this context, compulsory testing of pregnant women for HIV may constitute a form of discrimination.[376]

According to one scholar,

> *For mandatory testing to succeed…, the balance of benefits and harms would need to fall on the side of enabling the health and well-being of women during pregnancy. Otherwise, according to the Protocol, it could be construed as both discrimination and, far worse, violence against women to the extent that it limits protected freedoms and imposes on them a limitation that is not imposed on others.*[377]

Compulsory testing of pregnant women for HIV only further stigmatises and singles out a group that is already vulnerable.[378] In resource-poor settings, such as Kenya, pregnancy itself is often a condition of vulnerability during which "women require the assistance of their families, their social networks and the health care system."[379] Forcing women to undergo HIV testing during this time, while other members of society are not similarly required to do so, discriminates against pregnant women. According to a human rights advocate in this field, any policy of mandatory testing constitutes discrimination because it "is under-inclusive as it mainly targets pregnant women while other people in society who could be at risk are not subjected to similar treatment."[380] Mandatory testing "amounts to discrimination against women since only pregnant women are the targets of such a policy."[381]

The discrimination that pregnant women experience in this context may also exacerbate other aspects of their unequal treatment in Kenyan society. A human rights advocate in this field has recognised that "[m]andatory HIV testing for pregnant women may well place an undue burden on women and further reinforce prejudices and discrimination against women in society. At least one study has shown that pregnant women who have been found to be HIV-positive have been refused admission and delivery at hospitals."[382] In the context of a health care system that does not always enforce an individual's human rights, such as the right to privacy and the right to health, which were previously analysed in this report, women who are subject to mandatory testing cannot ensure that their status remains confidential and that they can access appropriate treatment. Therefore, forcing or coercing pregnant women to undergo HIV tests in connection with PMTCT treatment may further subject them to other forms of discrimination, such as domestic violence and the denial of health care, which are documented below.

Kenyan women living with HIV experience both gender- and health-based discrimination in their access to medical care. The Declaration of Commitment on HIV/AIDS, adopted at the UN General Assembly Special Session on HIV/AIDS in 2001, highlights that not only are governments accountable for reaching time bound targets for prevention of HIV/AIDS and access to essential medicines, but they must also eliminate discrimination in prevention and medical access.[383]

Hospitals must therefore provide access to quality care to all individuals, regardless of their HIV sero-status or gender. The discrimination that HIV-positive women experience when they seek health care constitutes an egregious violation of the right to health. The General Comment on Health elaborates that one of the entitlements included in the right to health is "the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health."[384] The comment also notes that "[h]ealth facilities, goods and services have to be accessible to everyone without discrimination . . . [and] must be within safe physical reach for all sections of the population, especially vulnerable or marginalised groups, such as . . . women . . . and persons with HIV/AIDS."[385] The reluctance of medical professionals to provide treatment to HIV-positive women, often choosing

to turn them away; the refusal of health care workers to provide women with family planning services and contraception; and the criticism that women experience at the hands of health care providers regarding their decision to bear children all contravene the protections guaranteed by this right and the rights to non-discrimination, equal protection, and equality before the law.

As mentioned in *Failure to Deliver*, the differences in health care services offered to women based on their ability to pay also violate their rights to equality and non-discrimination, particularly when women in need of antiretroviral treatment are unable to afford such care as a result of hidden fees associated with enrolling in a treatment regime.

The violence and stigma that women experience at the hands of their partners or members of their community constitute discrimination, as well. Women living with HIV risk incurring social stigma and abuse from their partners when they elect alternate-feeding methods for their infants and adhere to consistent ARV treatment regimes. The ESCR Committee's General Comment on Health elaborates that "[a] major goal should be . . . protecting women from domestic violence. . . . It is also important to undertake preventive, promotive and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights."[386] The Kenyan government must actively combat the stigma experienced by women living with HIV, which often results in domestic violence at the hands of their partners when they learn of the women's HIV status. Furthermore, the confluence of stigma around both HIV and cultural norms, such as exclusive breast feeding, hinders the ability of women living with HIV to exercise their reproductive rights.

The Kenyan government has an affirmative duty to address and remedy these manifestations of discrimination, in both the public and private sectors, through measures such as widespread awareness-raising campaigns. Furthermore, the government must take meaningful steps to address the disparate power dynamics between men and women in Kenyan society, which fuel the domestic violence experienced by many women who tell their partners about their HIV status, and which allow those partners to compromise the health of these women by preventing them from accessing appropriate HIV treatment.

The right to information

The right to information about health is fundamental to ensuring the reproductive rights of women. This right is particularly critical for women living with HIV, who must have secure access to information about this illness in order to prevent its transmission and to manage its effects, all while ensuring their reproductive health.

CEDAW requires that "[p]arties shall take all appropriate measures to eliminate discrimination against women . . . and in particular to ensure . . . [a]ccess to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning."[387] The convention further demands that states protect rural women's "access to adequate health care facilities, including information, counselling and services in family planning" and make certain that these women can obtain the "information, education and means" to exercise reproductive choice.[388] The CEDAW Committee has reiterated that "[i]n order to make an informed decision about safe and reliable contraceptive measures, women must have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services."[389]

Additionally, the ESCR Committee "interprets the right to health . . . as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to . . . health-related education and information, including on sexual and reproductive health."[390] Specifically, the ESCR Committee states that access to information in the context of the right to health includes "the right to seek, receive and impart information concerning health information . . . [but] should not impair the right to have personal health data treated with confidentiality."[391] The International Guidelines further maintain that states should adopt public-health legislation that ensures that "information relative to the HIV status of an individual be protected from unauthourised collection, use or disclosure in the health care and other settings and that the use of HIV-related information requires informed consent."[392]

African regional treaties also guarantee the right to information. The African Charter states that all people have the right to receive information and the right to education.[393] The Maputo Protocol includes the right to family planning education, and "obligates governments to provide adequate, affordable, and accessible health services, including information, education, and communication programmes, to all women, especially those in rural areas."[394]

Kenyan women routinely suffer from violations of their right to information in the context of HIV/AIDS and reproductive health care. When Kenyan health care providers impede women's access to information or provide them with inadequate information about this virus during pre- and post-test counselling for HIV, PMTCT and post-partum counselling, and HIV-treatment counselling, they commit egregious violations of the right to information. Similarly, the unwillingness of health care providers to discuss contraception and family planning options with HIV-positive women and the widespread refusal to follow informed consent procedures curtail this right.

National Law and Policy

Some protections for the rights set forth above are included in Kenya's existing national laws and policies.

The Constitution

The current Constitution of Kenya protects some of the rights outlined in this report. Chapter V of the Kenyan Constitution spells out the "Fundamental Rights and Freedoms of the Individual," which include the right to life[395] and the right to protection from torture and inhuman or degrading treatment.[396] A constitutional reform process has been ongoing for several years and a new Constitution will hopefully provide even more explicit protection for economic and social rights, such as the right to health.

The 2005 Draft Constitution expanded the definition of discrimination to include categories such as health status which is particularly relevant in the context of HIV/AIDS;[397] empowered the state to undertake affirmative action programmes where necessary for the benefit of disadvantaged groups;[398] specifically required that the state provide reasonable facilities and opportunities to enhance the welfare of women;[399] provided for the right to health (including the right to health care services and reproductive health care);[400] and clearly stated that the state must protect, promote and fulfill all human rights including "its international obligations in respect of human rights."[401] Although the Draft

Constitution was rejected in a national referendum, the issues in contention leading to its rejection did not include the recognition of economic and social rights.

Legislative Provisions and Governmental Policies

Since the president of Kenya declared the HIV/AIDS epidemic a national emergency in 1999, the nation has developed and adopted myriad guidelines, policies, and frameworks to combat HIV/AIDS that consider the role of family planning and reproductive health, including the Kenya National HIV/AIDS Strategic Plan 2005/6–2009/10. The most relevant of these policies, such as the PMTCT Guidelines and the VCT Guidelines, are discussed throughout this report in greater detail. However, effective implementation of these policies remains a significant problem, which dramatically limits their impact and efficacy.

Recommendations

The following recommendations are based upon the findings of this report and input from the women, health care providers, counsellors, and officials with whom FIDA Kenya/CRR spoke in the course of its research.

TO THE GOVERNMENT OF KENYA

Address factors which may deter health care staff from providing appropriate and quality care to HIV-positive clients.

- Train health care workers about:
  - the rights of patients to receive quality medical care, regardless of their HIV status.
  - the ways in which HIV is transmitted and the universal precautions they should take to prevent transmission, while continuing to provide quality care to patients living with HIV.
- Ensure that public and private health facilities have adequate supplies and access to HIV post-exposure prophylaxis, which will enable health care providers to take universal precautions against contracting HIV when treating patients and provide them with quality care.

Ensure that proper testing, counselling, and disclosure procedures are followed.

- Implement and enforce the various guidelines around HIV testing, including the VCT Guidelines and PMTCT Guidelines.
- Ensure that health care providers:
  - understand the components of pre-test counselling for HIV and that they counsel women about the importance of undergoing an HIV test, particularly those who are pregnant and seeking antenatal services.
  - offer adequate and informative post-test counselling for HIV/AIDS.
  - understand and maintain appropriate informed consent safeguards for HIV testing, particularly for pregnant women.
  - understand and maintain appropriate confidentiality procedures for disclosing a patient's HIV sero-status.
  - inform patients properly of their sero-status.
  - understand the importance of respecting a woman's decision on whether to tell her partner about her HIV sero-status.
- Employ HIV-positive women as HIV-testing counsellors.

Ensure that women's rights are protected in the context of PMTCT programs.

- Ensure that health care providers:
  - understand and maintain appropriate informed consent safeguards for HIV testing.
  - explain the "opt-out" testing procedure in a neutral and unbiased manner. Sensitise health care providers about obstacles that HIV-positive women may confront in accessing continuous and effective treatment, such as partner and community opposition to alternative-feeding practices, domestic violence, and discrimination, so that they can appropriately tailor PMTCT care to these women's needs.
  - supply accurate and adequate counselling, particularly in regard to infant-feeding practices.
- Employ HIV-positive women as PMTCT counsellors.
- Implement and enforce PMTCT Guidelines.
- Provide continuous training regarding the PMTCT Guidelines to Ministry of Health officials and health care providers in both private and public facilities.
- Ensure that regional NASCOP offices conduct trainings on the PMTCT Guidelines, at least quarterly.
- Increase publication, distribution, and dissemination of PMTCT Guidelines.

Address problems in the delivery of maternal health care, particularly for women who are living with HIV.

- Ensure that specialised obstetric care is offered to women who are HIV positive.
- Train health care providers in the precautions that they must take when delivering an HIV-positive pregnant woman, in order to prevent mother-to-child transmission of HIV.
- Ensure that the necessary ARV treatment is consistently administered to HIV-positive women during delivery to prevent mother-to-child transmission.
- Ensure that the supplies and equipment necessary to maintain hygienic conditions are available and that hygiene standards are strictly enforced to prevent the transmission of HIV.

Ensure that the rights of HIV-positive women are respected and protected when seeking reproductive health services.

- Educate health care staff on:
  - the right of women living with HIV to access family planning services and contraception.
  - the right of women living with HIV to be sexually active and to bear children.
- Train health care providers of family planning services to counsel women living with HIV and provide them with appropriate information to make informed family planning decisions.

Ensure greater access to ARVs.

- Increase the number of adequately trained staff that can provide counselling and distribution of ARVs at treatment centres.
- Sensitise health care providers about obstacles that HIV-positive women may confront in accessing continuous and effective ARV treatment uptake, such as domestic violence and discrimination, so that health care providers can appropriately advise these women on treatment access and uptake.
- Employ trained HIV-positive women at ARV treatment centres.

- Remove financial barriers that result in the denial of or delays in receiving ARV treatment.
    - Publicise which services are cost-exempt.
    - Clarify and clearly communicate costs associated with ARV treatment.
    - Ensure that women in need of HIV treatment are not turned away because they cannot pay the fees or costs associated with testing.

Conduct a public awareness campaign to combat stigma and discrimination related to HIV/AIDS.

- Emphasise the right of women to control their bodies and to decide how, when, and where to seek health care services and access HIV treatment.
- Emphasise the importance of couples peacefully communicating their HIV sero-status to one another and encouraging each other to seek treatment.
- Discourage the use of violence in reaction to learning of a partner's HIV sero-status and promote supportive information sharing and counselling between couples.
- Emphasise the right of women living with HIV to choose whether or not to be sexually active and whether or not to bear children.

Strengthen structures to protect patients' rights.

- Conduct public-awareness programmes to educate patients about their rights.
- Conduct mandatory trainings for all staff at health care facilities, including doctors, nurses, and clinical officers, in both public and private facilities, in order to continually educate them on medical advances, best practices, and patients' rights.
- Require all public and private health care facilities to establish formalised complaint mechanisms as part of their licensing requirements.
- Issue standards and guidelines for medical facilities on patients' rights and complaint mechanisms; ensure their widespread dissemination and implementation.
- Develop a clear complaint process to be adopted by all health facilities.
- Provide information to judges and legal professionals on rights violations in the health care context.

Strengthen Kenya's human rights framework.

- Ratify the African Charter's Protocol on the Rights of Women in Africa (Maputo Protocol).
- Domesticate international treaties and implement them at the national level.
- Create a constitutional framework that recognises key human rights, such as the right to health. Provide accountability and complaint mechanisms to protect and realise those rights.
- Address the problems with the HIV and AIDS Prevention and Control Act.
    - Remove the provisions from the act which violate human rights by permitting partner disclosure by health care workers and criminalising transmission.
    - Operationalise the strong human rights guarantees in the act and conduct a public awareness campaign around the act as well as training health care providers on its provisions.

TO ALL PUBLIC AND PRIVATE HEALTH CARE FACILITIES

Secure adequate protective gear and access to HIV post-exposure prophylaxis so that health care providers can take universal precautions in protecting themselves from contracting illnesses while treating their patients.

Ensure adequate staffing to provide patients with quality care.

Establish payment policies that are fair and transparent, and that safeguard patients' health.

- Do not turn away women seeking HIV treatment because they cannot pay a fee or other costs associated with HIV treatment.
- Ensure that women and their families are not required to bring supplies for delivery or other reproductive health services. Post the fee schedule for services in a prominent location and ensure that patients understand these fees.
- Ensure that patients understand the costs associated with ARV treatment regimes.

Develop adequate infrastructure and facilities to provide specialised care to women living with HIV before, during, and after delivery.

Protect patients' rights and promote accountability.

- Conduct trainings for all staff members on protecting the rights and dignity of patients; encourage health care staff to report rights violations.
- Post patients' rights in clear terms and prominent locations.

TO ASSOCIATIONS OF HEALTH CARE PROFESSIONALS IN KENYA

Revise ethical codes to provide sanctions for all discriminatory practices against women particularly in the context of HIV/AIDS and ensure that these provisions are widely publicised.

Emphasise the importance of respecting patients' rights in trainings and other activities for members.

TO THE WORLD BANK AND INTERNATIONAL MONETARY FUND

Examine the human rights consequences of conditions placed on funding and take necessary steps to ensure that these conditions do not result in rights violations, such as the denial of health care treatment for women who are HIV positive; ensure that these conditions do not weaken the health care system in other ways, such as by making it impossible to hire sufficient medical staff.

TO THE INTERNATIONAL DONOR COMMUNITY

Organisations financing public and private reproductive health, family planning, and HIV/AIDS programmes should ensure that such programmes are designed to improve health care and promote the exercise of women's rights, and should establish indicators for evaluating these projects, based on the criteria of efficiency, quality, and respect for women's human rights.

TO INTERNATIONAL AND AFRICAN HUMAN RIGHTS BODIES

Use the occasion of Kenya's periodic reports to the treaty-monitoring bodies to issue strong concluding observations and recommendations in order to reinforce Kenya's obligations to protect the rights of HIV-positive women seeking reproductive health care services and to provide redress and remedies for violations of these rights.

Endnotes

[1] Wanjiru Gichuhi, *Provision and Use of Family Planning in the Context of HIV/AIDS in Kenya: perspectives of providers, family planning and antenatal care clients, and HIV-positive women*, Feb. 2004, at 1.

[2] National Aids Control Council, *HIV and AIDS Situation in Kenya Based on Facts and Figures for 2006*, Aug. 13, 2007, at 2 [hereinafter NACC, HIV and AIDS Situation]. According to the HIV Sentinel Surveillance System, the total estimated prevalence rate of HIV positive women is 6.7%, while the prevalence rate of men is 3.5%. Additionally, the male to female prevalence ratio is 1.9.

[3] Central Bureau of Statistics, 2003 Kenya Demographic and Health Survey xxi (2004), at 221.

[4] *Id.* at 2.

[5] *Id.*

[6] Center for Reproductive Rights and Federation of Women Lawyers – Kenya, *Failure to Deliver: Violations of Women's Human Rights in Kenyan Health Facilities* 19, 46 (2007) [hereinafter *Failure to Deliver*].

[7] United Nations Population Fund (UNFPA) & World Health Organisation (WHO), *Sexual and reproductive health of women living with HIV/AIDS: Guidelines on care, treatment and support for women living with HIV/AIDS and their children in resource-constrained settings* at 1 (2006), *available at* http://www.who.int/hiv/pub/guidelines/sexualreproductivehealth.pdf (last visited May 14, 2008) [hereinafter SRH & HIV/AIDS Guidelines].

[8] Amnesty Int'l, *Women, HIV/AIDS and Human Rights*, AI Index ACT 77/084/2004, Nov. 2004, at 2, *available at* http://www.amnesty.org/en/library/info/ACT77/084/2004 (last visited May 14, 2008) [hereinafter Women, HIV/AIDS and HR].

[9] Interview with Dr. Joseph Karanja, Professor – University of Nairobi and Obstetrician - Gynecologist, Nairobi November 24, 2006.

[10] Kenyan HIV Positive Women's Network, *Violence in Kenya and its effect on PLHIV, especially Women and Children*, Jan. 14, 2008, http://www.icw.org/node/339 (last visited Jun. 20, 2008).

[11] Focus group discussion, unnamed participant, Kisumu, May 30, 2007.

[12] Focus group discussion, unnamed participant, Kisumu, May 30, 2007.

[13] HIV and AIDS Prevention and Control Act, No. 14 (2006) (Kenya) [hereinafter The HIV Act].

[14] Kenya Gazette Supplement, No. 98, at 466 (Jan. 2, 2007).

[15] The HIV Act, Part 24 (7).

[16] *Id.* Part 24 (1)(a)(b), (3).

[17] *Id.* Part 24 (2), (3).

[18] SRH & HIV/AIDS Guidelines at 1.

[19] *Id.*

[20] Ministry of Health (Kenya), *National Guidelines: Prevention of Mother-to-Child HIV/AIDS Transmission*, at 5 (2002) [hereinafter PMTCT Guidelines].

[21] SRH & HIV/AIDS Guidelines at 9.

[22] *Id.* at 8; Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The right to the highest attainable standard of health*, para. 8, U.N. Doc E/C.12/2000/4 (Aug. 11, 2000) [hereinafter CESCR General Comment No. 14]; Committee on the Elimination of Discrimination against Women, *General Recommendation 24: Women and health*, at para. 21, U.N. Doc. A/54/38 **(**Feb. 2, 1999) [hereinafter CEDAW General Recommendation No. 24].

[23] Office of the U.N. High Comm'r for Human Rights (OHCHR) and the Joint U.N. Programme on HIV/AIDS (UNAIDS), *International Guidelines on HIV/AIDS and Human Rights: 2006 Consolidated Version,* U.N. Doc HR/PUB/06/9, Sales No. E.06.XIV.4 (2006) [hereinafter International Guidelines]. These Guidelines address the human rights violations experienced by women living with HIV, including discrimination, poverty and violence.

[24] *Id.* para. 20(b).

[25] Women, HIV/AIDS and HR at 17.

[26] The International Guidelines on HIV/AIDS and Human Rights states that "public health legislation should ensure that HIV testing of individuals should only be performed with the specific informed consent of that individual." (International Guidelines at para. 20(b)). The General Comment on the Right to the Highest Attainable Standard of Health indicates that "[the right to health includes] the right to be free from interference, such as … non-consensual medical treatment." (CESCR General Comment No. 14 at para. 8). United Nations Committee on the Elimination of Discrimination against Women General Recommendation on Women and Health mandates that "[s]tates parties should … ensure access to quality health care services … Acceptable services are those which are delivered in a way that ensures that a woman gives her fully informed consent" (CEDAW General Recommendation No. 24 at para. 22). The HIV Act states that "… no person shall undertake an HIV test in respect of another person except … with the informed consent of that person" (HIV Act, Part ((IV) (14)(1)(a)). Kenya's VCT Guidelines indicate that "the consent of the client to have the counselling and testing must be informed. The service provider must ensure that there is no coercion … [In the case of pregnant women] …[t]he counselor must ensure that the mother thoroughly understands the benefits and risks of HIV testing and understands the additional services she will receive if HIV positive" (VCT Guidelines at 20). Kenya's PMTCT Guidelines state that "HIV testing in the antenatal clinic … should never be performed without consent, and pregnant women must be allowed the opportunity to 'opt-out' and to decline these services" (PMTCT Guidelines at 5).

[27] *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, G.A. Res. 199, U.N. GAOR, 46th Sess., Supp. No. 49 at Principle 11 (2), U.N. Doc. A/RES/46/119 (1992), *available at* http://www.unhchr.ch/html/menu3/b/68.htm (last visited May 14, 2008) [hereinafter Principles for the Protection of Persons with Mental Illness].

[28] Office of the U.N. High Commissioner for Human Rights & Joint U.N. Programme on HIV/AIDS, HIV/AIDS and Human Rights International Guidelines (1998) para. 80

[hereinafter UN Human Rights Guidelines], *available at* http://www.unaids.org/html/pub/publications/irc-pub02/jc520-humanrights_en_pdf.htm. (last visited May 14, 2008), para. 113.

29 The HIV Act, Part (I)(2).

30 Principles for the Protection of Persons with Mental Illness at Principle 11(2).

31 *Id*.

32 World Health Organisation, *Declaration on the Promotion of Patients' Rights in Europe* (Mar. 1994) [hereinafter WHO, Declaration on Patients' Rights].

33 UN Human Rights Guidelines, para. 80

34 WHO, Declaration on Patients' Rights at para. 2.2.

35 Council of Europe, *Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine*, art. 5, April 4, 1997, E.T.S. 164.

36 Principles for the Protection of Persons with Mental Illness at Principle 11(2)(d).

37 UN Human Rights Guidelines at para. 80.

38 Interview with Official – National AIDS and STD Control Programme (NASCOP), Nairobi, Dec. 6, 2007.

39 PMTCT Guidelines at 5.

40 Kenya Gazette Supplement, No. 98, at pp. 466 (Jan. 2, 2007).

41 The HIV Act, Part (I)(3)(b)(i).

42 *Id*. Part (IV)(13)(1).

43 *Id*. Part (IV)(14)(1)(a).

44 *Id*. Part (I)(2).

45 Interview with Steven Malai, Communications Officer – Advocacy – National AIDS Control Council (NACC), Nairobi, Nov. 20, 2007. Malai indicates: "The VCT Guidelines are currently undergoing review."

46 Prevention of Mother to Child Transmission is referred to both as PMTCT and PMCT, in Kenyan policy documents. As the more common usage, PMTCT will be used throughout the report.

47 National AIDS and STD Control Programme (NASCOP) with National AIDS Control Council (NACC), *National Guidelines for Voluntary Counselling and Testing*, at 1 (2001) [hereinafter VCT Guidelines].

48 *Id*. at v.

49 *Id*. at vi.

50 *Id*. at 20.

51 PMTCT Guidelines at 5.

52 Ebenezer Durojaye, *Addressing Human Rights Concerns Raised by Mandatory HIV Testing of Pregnant Women through the Protocol to the African Charter on the Rights of Women*, 52 Journal of African Law 43, 45 (2008) [hereinafter Durojaye, Addressing Human Rights Concerns].

53 Nat'l Coordinating Agency for Population and Dev., Ministry of Health & Central Bureau of Statistics, *2004 Kenya Service Provision Assessment Survey*, App. A, 35 (Nov. 2005) [hereinafter 2004 KSPAS].

54 National AIDS and STD Control Programme (NASCOP) and Ministry of Health, Kenya, *Preparedness for HIV/AIDS service delivery: The 2005 Kenya Health Workers Survey*, at 16-17 (2006) [hereinafter Kenya Health Workers Survey].

55 Interview with Prudence, Casual Worker – District Hospital Delivery Ward, Kisumu, Apr. 5, 2007.

56 *Id*.

57 Focus group discussion with unnamed participant, Kisumu, May 30, 2007.

58 Interview with Allan A. Maleche, Lawyer – Kenya Ethical and Legal Issues Network on HIV and AIDS (KELIN), Nairobi, Dec. 13, 2007.

59 Interview with Allan A. Maleche, Lawyer – KELIN, Nairobi, Dec. 13, 2007.

60 Interview with Official – NASCOP, Nairobi, Dec. 6, 2007.

61 Interview with Charles Oisebe, Senior Population Officer – National Coordinating Agency for Population and Development (NCAPD), Nairobi, Nov. 16, 2007.

62 Interview with Steven Malai, Communications Officer-Advocacy - NACC, Nairobi, Nov. 20, 2007.

63 *Id*.

64 Interview with Edith Atieno, Post-Counselor – Women Fighting AIDS in Kenya (WOFAK), Nairobi, Nov. 21, 2007.

65 *Id*.

66 *Id*.

67 The HIV Act, Part 11 (2), (3).

68 PMTCT Guidelines at 14.

69 National AIDS and STD Control Programme (NASCOP), *Guidelines for Antiretroviral Drug Therapy in Kenya,* 3rd. ed., at 79 (2001) [hereinafter ART Guidelines].

70 *Failure to Deliver* at 19, 46

71 Interview with Allan A. Maleche, Lawyer – KELIN, Nairobi, Dec. 13, 2007.

72 *Id*.

73 *Id*.

74 *Id*.

75 ART Guidelines at 79-81.

76 *Id*. at 81.

77 Russell Armstrong, *Mandatory HIV Testing in Pregnancy: Is There Ever a Time?*, 8 Dev. World Bioethics 1, 3 (April 2008) [hereinafter Armstrong, Mandatory HIV Testing in Pregnancy].

78 Armstrong, Mandatory HIV Testing in Pregnancy at 3.

79 SRH & HIV/AIDS Guidelines at 30.

80 International Guidelines at para. 105.

81 *Id*. para. 114.

82 *Id*. para 96.

83 *Id*. para 105.

84 Durojaye, Addressing Human Rights Concerns at 49.

85 Armstrong, Mandatory HIV Testing in Pregnancy at 7.

86 2004 KSPAS at 112.

87 Interview with Allan A. Maleche, Lawyer – KELIN, Nairobi, Dec. 13, 2007.

88 *Id*.

89 SRH & HIV/AIDS Guidelines at 30.

90 The HIV Act, Part (IV)(18)(a).

91 VCT Guidelines at vi.

92 Focus group discussion, unnamed participant, Kisumu, May 30, 2007.

93 Focus group discussion, unnamed participant, Kisumu,

May 30, 2007.

[94] 2004 KSPAS at App. A, 39.

[95] Interview with Dr. Joseph Karanja, Professor – University of Nairobi and Obstetrician - Gynecologist, Nairobi, November 24, 2006.

[96] *Id.*

[97] Interview with Prudence, Casual Worker – District Hospital Delivery Ward, Kisumu, Apr. 5, 2007.

[98] *Failure to Deliver* at 44.

[99] CESCR General Comment No. 14 at para. 12.; CEDAW General Recommendation No. 24 at para. 22.

[100] The HIV Act, Part (V)(22)(1).

[101] *Id.*

[102] PMTCT Guidelines at 7.

[103] SRH & HIV/AIDS Guidelines at 24.

[104] International Guidelines at para. 20(c).

[105] The HIV Act, Part (IV)(17)(1).

[106] SRH & HIV/AIDS Guidelines at 9.

[107] Kenya Health Workers Survey at 44.

[108] VCT Guidelines at 20.

[109] PMTCT Guidelines at 5.

[110] *Id.*

[111] *Id.* at 6.

[112] Focus group discussion with unnamed participant, Kisumu, May 30, 2007.

[113] Focus group discussion with unnamed participant, Kisumu, May 30, 2007.

[114] Focus group discussion with unnamed participant, Kisumu, May 30, 2007.

[115] Focus group discussion with unnamed participant, Kisumu, May 30, 2007.

[116] The HIV Act, Part (I)(2).

[117] Focus group discussion, unnamed participant, Kisumu, May 30, 2007.

[118] Focus group discussion, unnamed participant, Kisumu, May 30, 2007.

[119] Focus group discussion, unnamed participant, Kisumu, May 30, 2007.

[120] VCT Guidelines at 16.

[121] PMTCT Guidelines at 8.

[122] PMTCT Guidelines at 8.

[123] Kenya Health Workers Survey at 44.

[124] 2004 KSPAS at App. A, 36, Table A-2.2.

[125] *Id.* at 63, Table A-3.10.

[126] Center for Reproductive Rights, *Pregnant Women Living with HIV/AIDS: Protecting Human Rights in Programs to Prevent Mother-to-Child Transmission of HIV*, 3 fn 12 (August 2005), *available at* http://www.reproductiverights.org/pdf/pub_bp_HIV.pdf (last viewed May 14, 2008).

[127] WHO and UNICEF, Guidance on Global Scale-up of the Prevention of Mother-to-Child Transmission of HIV http://www.who.int/hiv/mtct/PMTCT_enWEBNov26.pdf (last viewed May 14, 2008) [hereinafter PMTCT Guidance].

[128] SRH & HIV/AIDS Guidelines at 31. According to PMTCT Guidance at 1, "[t]he overall risk can be reduced to less than 2% by a package of evidence-based interventions."

[129] *Id.*

[130] PMTCT Guidelines at 24.

[131] *Id.* at 25.

[132] SRH & HIV/AIDS Guidelines at 37.

[133] International Guidelines at para. 60(f).

[134] SRH & HIV/AIDS Guidelines at 3.

[135] Focus group discussion, unnamed participant, Kisumu, May 30, 2007.

[136] 2004 KSPAS at xii.

[137] Kenya Health Workers Survey at 35.

[138] *Id.* at viii.

[139] *Id.* at 28-29.

[140] The HIV Act, Part (II)(6)(2)

[141] Interview with Official – NASCOP, Nairobi, Dec. 6, 2007.

[142] Interview with Official – NASCOP, Nairobi, Dec. 6, 2007.

[143] Interview with Official – NASCOP, Nairobi, Dec. 6, 2007.

[144] Interview with Official – NASCOP, Nairobi, Dec. 6, 2007.

[145] Family Health International, Country Assessment: Kenya, Family Planning Needs in the Context of the HIV/AIDS Epidemic 4 (Oct. 2004) [hereinafter Country Assessment: Kenya].

[146] Interview with Official – NASCOP, Nairobi, Dec. 6, 2007.

[147] Kenya Health Workers Survey at 36.

[148] International Guidelines at para. 60(b).

[149] *Id.* at para. 18.

[150] Focus group discussion, unnamed participant, Kisumu, May 30, 2007.

[151] Women, HIV/AIDS and HR at 12.

[152] *Id.* at 12.

[153] *Access to medication in the context of pandemics such as HIV/AIDS, tuberculosis and malaria, adopted* Apr. 22, 2003, C.H.R. Res. 2003/29, U.N. Doc. E/CN.4/RES/2003/29 (2003).

[154] International Guidelines at para. 37.

[155] SRH & HIV/AIDS Guidelines at 60.

[156] *Id.* at 55.

[157] PMTCT Guidelines at 13.

[158] Ministry of Health (Kenya), *Facts and Figures at a Glance: Health and Health Related Indicators* at 41 (2006) [hereinafter Facts and Figures at a Glance].

[159] Women, HIV/AIDS and HR at 31.

[160] 2004 KSPAS at 24.

[161] Focus group discussion, unnamed participant, Kisumu, May 30, 2007.

[162] Focus group discussion, unnamed participant, Kisumu, May 30, 2007.

[163] 2004 KSPAS at 26.

[164] Kenyan Health Workers Survey at xi.

[165] Focus group discussion, unnamed participant, Kisumu, May 31, 2007.

[166] According to a NASCOP official, ARV treatment for PMTCTs is widely accessible, *see,* Interview with Official – NASCOP, Nairobi, Dec. 6, 2007

[167] Interview with Official – NASCOP, Nairobi, Dec. 6, 2007.

[168] 2004 KSPAS at 26.

[169] Facts and Figures at a Glance at 37, fig. 9.9.

[170] Interview with Official – NASCOP, Nairobi, Dec. 6, 2007.

[171] Interview with Official – NASCOP, Nairobi, Dec. 6, 2007.

[172] Country Assessment: Kenya, pg. 8; Interview with Official – NASCOP, Nairobi, Dec. 6, 2007.

[173] Focus group discussion, unnamed participant, Kisumu, May 30, 2007.

[174] Focus group discussion, unnamed participant, Kisumu, May 30, 2007.
[175] International Community of Women Living with HIV/AIDS (ICW), *Mapping of Experiences of Access to Care, Treatment and Support – Kenya*, at 1 (2006) [hereinafter Access to Care].
[176] *Id.* at 2.
[177] Interview with Florence, Kasarani, Nov. 29, 2006.
[178] Interview with Official – NASCOP, Nairobi, Dec. 6, 2007.
[179] Interview with Allan A. Maleche, Lawyer – KELIN, Nairobi, Dec. 13, 2007.
[180] *Id.*
[181] *Id.*
[182] 2004 KSPAS at 24.
[183] Interview with Allan A. Maleche, Lawyer – KELIN, Nairobi, Dec. 13, 2007.
[184] *Id.*
[185] *Id.*
[186] *Id.*
[187] *Failure to Deliver* at 60.
[188] Interview with Allan A. Maleche, Lawyer – KELIN, Nairobi, Dec. 13, 2007.
[189] Facts and Figures at a Glance at 35, fig. 9.5.
[190] Interview with Official – NASCOP, Nairobi, Dec. 6, 2007.
[191] Interview with Official – NASCOP, Nairobi, Dec. 6, 2007.
[192] *Failure to Deliver* at 15.
[193] Interview with Official – NASCOP, Nairobi, Dec. 6, 2007. Initially, the ARV treatment centres were located in district hospitals, which contributed to the limited numbers of facilities and inaccessible location for many patients. Currently, new facilities are opening at sub-district levels, and are organised into central and satellite sites. The central sites are district hospitals, and the satellite sites are health centres and dispensaries throughout the country.
[194] Interview with Official – NASCOP, Nairobi, Dec. 6, 2007.
[195] 2004 KSPAS at xi.
[196] *Id.* at 24.
[197] Interview with Official – NASCOP, Nairobi, Dec. 6, 2007. The NASCOP official noted that the health care professionals determine which patients will receive the limited quantity of ARVs according to the conditions of the patients. Patients are monitored and those with lower CD4 counts receive treatment.
[198] *Failure to Deliver* at 54.
[199] *Id.*
[200] Access to Care at 2.
[201] *Id.*
[202] Interview with Official – NASCOP, Nairobi, Dec. 6, 2007.
[203] Access to Care at 2.
[204] Interview with Official – NASCOP, Nairobi, Dec. 6, 2007; PMTCT Guidelines at 13.
[205] Access to Care at 2.
[206] Interview with Official – NASCOP, Nairobi, Dec. 6, 2007.
[207] *Failure to Deliver* at 51.
[208] Access to Care at 2.
[209] Focus group discussion, unnamed participant, Kisumu, May 30, 2007.
[210] Focus group discussion, unnamed participant, Kisumu, May 30, 2007.
[211] Focus group discussion, unnamed participant, Kisumu, May 30, 2007.
[212] Focus group discussion, unnamed participant, Kisumu, May 31, 2007.
[213] Interview with Official – NASCOP, Nairobi, Dec. 6, 2007; *Failure to Deliver* at 54.
[214] Interview with Official – NASCOP, Nairobi, Dec. 6, 2007
[215] *Failure to Deliver* at 54.
[216] Access to Care at 2.
[217] *Failure to Deliver* at 51.
[218] Interview with Charles Oisebe, Senior Population Officer – NCAPD, Nairobi, Nov. 16, 2007.
[219] Interview with Steven Malai, Communications Officer – Advocacy – NACC, Nairobi, Nov. 20, 2007.
[220] *Failure to Deliver* at 28.
[221] SRH & HIV/AIDS Guidelines at 28.
[222] PMTCT Guidelines at 11.
[223] Country Assesment: Kenya at 1.
[224] SRH & HIV/AIDS Guidelines at 34.
[225] Focus group discussion, unnamed participant, Kisumu, May 30, 2007.
[226] PMTCT Guidelines at 16.
[227] *Id.*
[228] Focus group discussion, unnamed participant, Kisumu, May 30, 2007.
[229] PMTCT Guidelines at 39.
[230] *Id.* at 16.
[231] 2004 KSPAS at xii.
[232] PMTCT Guidelines at 17.
[233] *Failure to Deliver* at 46.
[234] *Id.* at 47.
[235] Focus group discussion, unnamed participant, Kisumu, May 31, 2007.
[236] *Failure to Deliver* at 49.
[237] Focus group discussion, unnamed participant, Kisumu, May 31, 2007.
[238] Kenya Health Workers Survey at xii.
[239] *Id.* at viii.
[240] Interview with Allan A. Maleche, KELIN, December 13, 2007.
[241] Facilities include hospitals, health centers, maternities, clinics, dispensaries, and stand-alone VCT clinics. 2004 KSPAS at 2.
[242] 2004 KSPAS at fig. 1.1.
[243] Kenya Health Workers Survey at 32.
[244] *Id.* at xii-xiii.
[245] Interview with Evelyn Mutio, Nurse/Administrator - Mukunga Clinic, Dandora, Feb. 1, 2007.
[246] Focus group discussion, unnamed participant, Kisumu, May 30, 2007.
[247] Focus group discussion, unnamed participant, Kisumu, May 30, 2007.
[248] *Failure to Deliver* at 26.
[249] SRH & HIV/AIDS Guidelines at 8.
[250] The HIV Act, Part (IV)(19)(1).
[251] Interview with Jane, Kasarani Maternity Hospital, Kasarani, June 6, 2006. Jane, who was HIV-positive and eight months pregnant, indicated that she would deliver

her baby at Kasarani Maternity Hospital, although the fee was difficult to afford.

[252] Focus group discussion, unnamed participant, Kisumu, May 30, 2007.

[253] Focus group discussion, unnamed participant, Kisumu, May 30, 2007.

[254] Focus group discussion, unnamed participant, Kisumu, May 30, 2007.

[255] Focus group discussion, unnamed participant, Kisumu, May 30, 2007.

[256] The HIV Act, Part (VIII)(36).

[257] PMTCT Guidelines at 143.

[258] Kenya Health Workers Survey at xi.

[259] Interview with Edith Atieno, Post-Counselor - WOFAK, Nairobi Nov. 21, 2007.

[260] Focus group discussion, unnamed participant, Kisumu, May 30, 2007.

[261] Interview with Allan A. Maleche, Lawyer – KELIN, Nairobi, Dec. 13, 2007.

[262] *Id.*

[263] *Id.*

[264] *Id.*

[265] *Id.*

[266] *Id.*

[267] *Id.*

[268] ART Guidelines at 84.

[269] Country Assessment: Kenya at 9.

[270] Focus group discussion, unnamed participant, Kisumu, May 30, 2007.

[271] Focus group discussion, unnamed participant, Kisumu, May 30, 2007.

[272] Interview with Professor – University of Nairobi and Obstetrician - Gynecologist, Nairobi Mar. 24, 2006 (name withheld).

[273] Kristin Kalla & Jonathan Cohen, *Ensuring Justice For Vulnerable Communities In Kenya*, Open Society Institute (2007) at 19. [hereinafter *Ensuring Justice For Vulnerable Communities*].

[274] Interview with Allan A. Maleche, Lawyer – KELIN, Nairobi, Dec. 13, 2007.

[275] *Id.*

[276] *Id.*

[277] *Id.*

[278] *Id.*

[279] *Ensuring Justice for Vulnerable Communities* at 17.

[280] *Id.* at 21.

[281] Violations of women's property rights around HIV are rife in sub-Saharan Africa, *See* Human Rights Watch, *Hidden in the Mealie Meal: Gender Based Abuses and Women's HIV Treatment In Zambia* (2007), particularly in Kenya, see *Ensuring Justice for Vulnerable Communities.*

[282] Interview with Allan A. Maleche, Lawyer – KELIN, Nairobi, Dec.13, 2007.

[283] *Id.*

[284] *Id.*

[285] Interview with Steven Malai, Communications Officer – Advocacy – NACC, Nairobi, Nov. 20, 2007.

[286] *Id.*

[287] Durojaye, Addressing Human Rights Concerns at 51.

[288] *Ensuring Justice for Vulnerable Communities* at 7.

[289] *Id.*

[290] *Id.* at 27.

[291] Wife, or widow, inheritance occurs when a woman is forced to marry the brother of her deceased spouse. *Ensuring Justice for Vulnerable Communities* at 16.

[292] Focus group discussion, unnamed participant, Kisumu, May 31, 2007.

[293] Focus group discussion, unnamed participant, Kisumu, May 31, 2007.

[294] Focus group discussion, unnamed participant, Kisumu, May 30, 2007.

[295] Interview with Jane, Kasarani Maternity Hospital, Kasarani, June 6, 2006.

[296] African Charter on Human and Peoples' Rights, *adopted* June 27, 1981, O.A.U. Doc. CAB/LEG/67/3, rev.5, 21 I.L.M. 58 (1982) (*entered into force* Oct. 21, 1986) [hereinafter African Charter]. The African Charter obliges state parties to "ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions." Article 18(3).

[297] African Charter on Rights and Welfare of the Child, (*adopted* July 1990) O.A.U. Doc. CAB/LEG/24.9/49 (*entered into force* Nov. 29, 1999) [hereinafter African Charter on Children].

[298] Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, *adopted* July 11, 2003, 2nd African Union Assembly, Maputo, Mozambique [hereinafter Maputo Protocol].

[299] African Commission on Human and Peoples' Rights, Status of Ratification/Accession to OAU/AU Human Rights Treaties, http://www.achpr.org/english/_info/index_ratifications_en.html (last visited June 13, 2007).

[300] Vienna Convention on the Law of Treaties, art. 18(a), May 23, 1969, 1155 U.N.T.S. 331, 8 I.L.M. 679 (*entered into force* Jan. 27, 1980) [hereinafter Vienna Convention].

[301] Maputo Protocol at art. 26.

[302] International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976) [hereinafter Civil and Political Rights Covenant].

[303] International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, at 49, U.N. Doc A/6316 (1966), 999 U.N.T.S. 3 (*entered into force* Jan. 3, 1976) [hereinafter Economic, Social and Cultural Rights Covenant].

[304] Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (1979) (*entered into force* Sept. 3, 1981) [hereinafter CEDAW].

[305] Convention on the Rights of the Child, *adopted* Nov. 20, 1989, G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess., Supp. No. 49, at 166, UN Doc. A/44/49 (1989), *reprinted in* 28 I.L.M. 1448 (*entered into force* Sept. 2, 1990) [hereinafter Children's Rights Convention].

[306] Convention against Torture and Other Cruel, Inhuman

or Degrading Treatment or Punishment, *adopted* Dec. 10, 1984, G.A. Res. 39/46, U.N. GAOR, 39th Sess., Supp. No. 51, at 197, U.N. Doc. A/39/51 (1984), 1465 U.N.T.S. 85 (*entered into force* June 26, 1987) [hereinafter Convention against Torture].

[307] Vienna Convention at art. 2.1(b). *See also, Vienna Declaration and Programme of Action*, *World Conference on Human Rights*, para. 1, Vienna, Austria, July 14-25, 1993, U.N. Doc. A/CONF 157/23 (1993) (reaffirming "the solemn commitment of all States to fulfil their obligations to promote universal respect for, and observance and protection of, all human rights and fundamental freedoms for all in accordance with the Charter of the United Nations, other instruments relating to human rights, and international law.") [hereinafter Vienna Declaration and Programme of Action].

[308] *See, e.g.* Political Declaration on HIV/AIDS, G.A. Res. 60/262, Annex, U.N. Doc. A/RES/60/262 (2 Jun. 2006) (voicing deep concern about the gender inequalities of the HIV/AIDS pandemic, reaffirming that "full realization of all human rights . . . for all is an essential element in the global response to the HIV/AIDS pandemic, including in the areas of prevention, treatment, care and support, and recognize that addressing stigma and discrimination is also a critical element in combating the global HIV/AIDS pandemic," and emphasising the need to strengthen policy and programs related to HIV/AIDS and reproductive health); Declaration of Commitment on HIV/AIDS, G.A. Res. 26/2, Annex, U.N. Doc. A/RES/S-26/2 (27 Jun. 2001) (recognising that "establishing and strengthening human resources and national health and social infrastructures as imperatives for the effective delivery of prevention, treatment, care and support services" to fight the HIV/AIDS pandemic).

[309] *See, e.g.* CEDAW at art. 12; Economic, Social and Cultural Rights Covenant at art. 12; *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept 5-13, 1994, U.N. Doc A/CONF.171/13/Rev.1 (1995) [hereinafter ICPD Programme of Action]; Beijing Declaration and Platform for Action at para. 89; Children's Rights Convention,at art. 166; African Charter at art. 16; Maputo Protocol at 14 .

[310] CESCR General Comment No. 14 at paras. 8 and 12.

[311] Economic, Social and Cultural Rights Covenant at art. 2.

[312] Committee on Economic, Social and Cultural Rights, *General Comment No. 3: The nature of States parties obligations,* U.N. Doc. E/1991/23 at para. 9 (Dec. 14, 1990) [hereinafter CESCR General Comment No. 3].

[313] CESCR General Comment No. 14. at para. 12 (stating that accessibility consists of non-discrimination, physical accessibility, affordability, and access to information). The U.N. Special Rapporteur on the right to health has recently affirmed these necessary components of the right to health. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, paras. 68, 71, U.N. Doc. A/HRC/4/28 (Jan. 17, 2007).

[314] CESCR General Comment No. 14 at para. 12.

[315] *Id.* para. 12(b).

[316] International Guidelines at para. 44.

[317] CESCR General Comment No. 14 at para. 36.

[318] *Failure to Deliver* at 79.

[319] CESCR General *Comment* No. 14 at para. 16.

[320] International Guidelines at para. 6.

[321] Civil and Political Rights Covenant at art. 17.

[322] Universal Declaration of Human Rights, art. 12, *adopted* Dec. 10, 1948, G.A. Res. 217A(III), at 71, U.N. Doc A/810 (1948) [hereinafter Universal Declaration].

[323] The Constitution of Kenya ch. V, sect. 70 (2001).

[324] Civil and Political Rights Covenant at 17.

[325] Human Rights Committee, *General Comment 16: The right to respect privacy, family, home and correspondence,* paras. 1, 9 (Apr. 8, 1988) [hereinafter HRC General Comment No. 16].

[326] ICPD *Programme of Action* at ch. VII.

[327] CESCR General Comment No. 14 at para. 3.

[328] *Id.* para. 8.

[329] International Guidelines at para. 111.

[330] *Id.* para. 20(b).

[331] *Id.* para. 20(c).

[332] *Id.* para. 114.

[333] *Id.*

[334] *Id.* para. 118.

[335] CEDAW General Recommendation No. 24 at para. 31(e).

[336] Maputo Protocol at art. 4(h); Civil and Political Rights Covenant at art. 7. *See also*, CCPR General Comment No. 20 (explaining that "Article 7 expressly prohibits medical or scientific experimentation without the free consent of the person concerned."). Similarly, the CEDAW Committee has affirmed a woman's right to information regarding health care and treatment options, stating that the government has an obligation to prohibit "forms of coercion … that violate women's rights to informed consent and dignity." CEDAW General Recommendation No. 24 at paras. 20, 22.

[337] International Guidelines at para. 120.

[338] *Id.*

[339] HRC General Comment No. 16 at para. 1.

[340] *See, e.g.,* Human Rights Committee, *General Comment 16: The right to respect privacy, family, home and correspondence*, para. 10 (Apr. 8, 1988),(affirming the right of individuals to access files containing their personal data) [hereinafter CCPR General Comment No. 16].

[341] International Guidelines at para. 120.

[342] World Health Organisation, Patients' rights*, available at* http://www.who.int/genomics/public/patientrights/en/ (last visited May 14, 2008).

[343] Universal Declaration at art. 5; Civil and Political Rights Covenant at art. 52; Convention against Torture at arts 2, 16 ; African Charter at art. 5; African Charter on Children at art. 16. In addition, the Maputo Protocol prohibits "[a]ll forms of exploitation, cruel, inhuman or degrading punishment and treatment," and requires state parties to take measures to protect women from all forms of sexual violence. Maputo Protocol at arts. 3, 4; The Constitution of Kenya ch. V, sect. 74(1).

[344] Human Rights Committee, *General Comment 20: Replaces general comment 7 concerning prohibition of torture and cruel treatment or punishment*, U.N. Doc. HRI/GEN/1/Rev.1 at 30, para. 7 (1994) [hereinafter HRC General Comment No. 20].

[345] *Id.* para. 5.

[346] *Id.* para. 2.

[347] Universal Declaration at art. 3; Civil and Political Rights Covenant at art. 6; African Charter at art. 4; Children's Rights Convention art. 6; The Constitution of Kenya ch. 5 sect. 70(a).

[348] Human Rights Committee *General Comment No. 6, The right to life*, U.N. Doc. 30/04/82 (1982) [hereinafter HRC General Comment No. 6].

[349] HRC General Comment No. 6 at para. 5.

[350] International Guidelines at para. 145.

[351] Human Rights Committee, *General Comment 31, Nature of the General Legal Obligation Imposed on States Parties to the Covenant*, para. 8., U.N. Doc. CCPR/C/21/Rev.1/Add.13 (May 26, 2004).

[352] Universal Declaration at art. 3; Civil and Political Rights Covenant at art. 6; African Charter at art. 4; Children's Rights Convention at art. 6; The Constitution of Kenya ch. 5 sect. 70(a).

[353] *See, e.g.* Committee on the Elimination of Discrimination against Women, *General Recommendation No. 19, Violence against women*, para. 24(m), U.N. Doc. A/47/38 (Jan. 29, 1992).

[354] Office of the High Commissioner for Human Rights Briefing Session, *Implementation of HIV-AIDS Related Rights* (April 19, 2000), *available at* http://www.unhchr.ch/html/menu2/7/b/briefaids.htm (last visited May 14, 2008).

[355] World Health Organisation, *Declaration on the Promotion of Patients' Rights in Europe*, arts. 1.2, 1.3, 3.1, 3.2 (Mar. 1994).

[356] International Guidelines at para. 135.

[357] Universal Declaration at art. 1; Civil and Political Rights Covenant at preamble; African Charter at art. 5; African Charter on Children at art. 11(5).

[358] International Guidelines at para. 101.

[359] Civil and Political Rights Covenant at preamble.

[360] African Charter at art. 5.

[361] Maputo Protocol at art. 13.

[362] Committee on the Elimination of Discrimination against Women, *General Recommendation 15: Avoidance of discrimination against women in national strategies for the prevention and control of acquired immunodeficiency syndrome (AIDS),* (Ninth session, 1990), U.N. Doc. A/45/38 at 81 (1990), reprinted in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.6 at 240 (2003).

[363] *Hoffman v. South African Airways,* (2001) 1. S.Afr.L.R. 1 (S.Afr.Const.Ct) at para. 28.

[364] Universal Declaration at art.16; Civil and Political Rights Covenant at art 23; Economic, Social and Cultural Rights Covenant at art. 10.

[365] Civil and Political Rights Covenant at art. 23.

[366] Human Rights Committee, *General Comment No. 19: Protection of the family, the right to marriage and equality of the spouses*, para. 23 (Thirty-ninth session, 1990), Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.6 at 149, para. 5 (2003).

[367] Economic, Social and Cultural Rights Covenant at art. 10.

[368] African Charter at art.18.

[369] *Id.*

[370] Civil and Political Rights Covenant at art 2(1); Economic, Social and Cultural Rights Covenant at 2(2).

[371] Human Rights Committee, *Sub-Commission on the Prevention of Discrimination and Protection of Minorities*, RES 1995/21 (*adopted* August 24, 1995).

[372] *See,* Report of the Special Rapporteur, *Economic, Social and Cultural Rights: the right of everyone to the highest attainable standard of physical and mental health*, U.N. Doc. E/CN.4/2004/49, (Feb. 16, 2004).

[373] Armstrong, Mandatory HIV Testing in Pregnancy at 4.

[374] International Guidelines at para. 22(f).

[375] Maputo Protocol at art. 2(1)(b).

[376] Armstrong, Mandatory HIV Testing in Pregnancy at 5.

[377] *Id.*

[378] *Id.* at 7.

[379] *Id.* at 8.

[380] Durojaye, Addressing Human Rights Concerns at 55.

[381] *Id.* at 64.

[382] *Id.* at 55.

[383] Declaration of Commitment on HIV/AIDS, G.A. Res. 26/2, Annex, U.N. Doc. A/RES/S-26/2 (27 Jun. 2001).

[384] CESCR General Comment No. 14 at para. 8.

[385] *Id.* para. 12(b).

[386] *Id.* para. 21.

[387] CEDAW at art. 10.

[388] *Id.* arts. 14(2)(b), 16(1)(e).

[389] Committee on the Elimination of Discrimination against Women, *General Recommendation 21: Equality in marriage and family relations* (Thirteenth session, 1992), U.N. Doc. A/49/38 at 1 (1994), reprinted in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.6 at 250 (2003).

[390] CESCR General Comment No. 14 at para. 11.

[391] *Id.* para. 12(b).

[392] International Guidelines at para. 20(f).

[393] African Charter at arts. 9(1), 17(1).

[394] Maputo Protocol at art. 14.

[395] The Constitution of Kenya at ch. V, sect. 70(a).

[396] *Id.* ch. V, sect. 74(1).

[397] The Proposed New Constitution of Kenya (2005), Kenya Gazette Supplement No. 63, at art. 37 (Aug. 22, 2005) [hereinafter referred to as the Draft Constitution].

[398] Draft Constitution at art. 37(4).

[399] *Id.* art. 38(4).

[400] *Id.* art. 61.

[401] *Id.* art. 31(1).

The Kenyan government is failing women living with HIV, and the consequences of this failure are tragic. As *At Risk: Rights Violations of HIV-Positive Women in Kenyan Health Facilities* vividly illustrates, widespread problems in the Kenyan health-care sector are preventing HIV-positive women from obtaining the affordable, accessible, and safe health services that the government is obligated to provide under international law.

The report, produced by the Federation of Women Lawyers—Kenya and the Center for Reproductive Rights, documents the human rights violations and barriers to quality health care that women living with HIV experience in Kenya—physical and verbal abuse at health-care centers, violations of informed consent and confidentiality in connection with HIV testing, inadequate counseling about HIV testing and treatment and the prevention of mother-to-child transmission of HIV/AIDS, discriminatory standards of care for HIV-positive women, lack of access to antiretroviral treatment, shortages of staff and equipment, and the absence of hygienic conditions—and calls on the Kenyan government to implement systemic changes to ensure that women can fully exercise their right to quality care.

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