REPUBLIC OF KENYA

IN THE HIGH COURT OF KENYA AT MILIMANI NAIROBI

CONSTITUTIONAL AND HUMAN RIGHT DIVISION

PETITION NO 150 OF 2016 CONSOLIDATED WITH

PETITION NO. 234 OF 2016

IN THE MATTER OF THE ENFORCEMENT OF THE BILL OF RIGHTS UNDER ARTICLE 22(1) OF THE CONSTITUTION OF KENYA (2010)

AND

IN THE MATTER OF THE ALLEGED CONTRAVENTON OF ARTICLES 2, 10, 27, 28, 29, 31, 43 AND 50 OF THE CONSTITUTION OF KENYA (2010)

AND

IN THE MATTER OF ARTICLES 1,2,3,7,9,12, 28 OF THE UNITED NATIONS UNIVERSAL DECLARATION OF HUMAN RIGHTS

AND

IN THE MATTER OF ARTICLES 2,3,4,6,10,19,28 OF THE AFRICAN CHARTER ON HUMAN AND PEOPLES RIGHTS.

AND

IN THE MATTER OF SECTIONS 162 AND 165 OF THE PENAL CODE CAP 63 LAWS OF KENYA

BETWEEN

JOHN MATHENGE……………………..……………………………1st PETITIONER

MAUREEN OCHIENG…………………….……….....……………....2nd PETITIONER

MARY AKOTH OCHIENG……………………….………...……3rd PETITIONER

YVONE POWERS…………………………………….……………….4th PETITIONER

MARK ODHIAMBO……………………………………......……..5th PETITIONER

GAY AND LESBIAN COALITION OF KENYA…………….…………6th PETITIONER

NYANZA WESTERN AND RIFT VALLEY NETWORK…………..…..7th PETITIONER

KENYA HUMAN RIGHTS COMMISSION……………...………8th PETITIONER

AND

ATTORNEY GENERAL……………………………………………………RESPONDENT

AND

KENYA LEGAL & ETHICAL ISSUES

NETWORK ON HIV &AIDS……………………………...….INTERESTED PARTY

INTERESTED PARTY SUBMISSIONS

INTRODUCTION

1. These written submissions are submitted by Kenya Legal & Ethical Issues Network on HIV & Aids (KELIN) pursuant to leave granted by this Court on 18 January 2018. KELIN is an independent non-governmental organization that was established to tackle the legal and ethical issues related to HIV and AIDS and to promote access to quality health care for all in Kenya. KELIN currently operates and works in five (5) countries through partnerships with other stakeholders in East Africa and Southern Africa to protect and promote HIV related human rights including the human rights of marginalized groups living on the periphery of mainstream society such as lesbian, gay, bisexual and transgender (LGBT) individuals by providing legal services and support to challenge discrimination and denial of health care services based on sexual orientation.

2. This case raises critical questions concerning the right to access health care, in particular, the right to access to health care services for the LGBTI individuals, including access to HIV care and prevention, and the negative impact of discrimination arising from laws criminalising consensual same-sex activity. Though this court has given positive decisions that have affirmed the rights of persons living with HIV, it has yet to deliver judgment on the impact of the

enforcement of section 162 and 165 of the Penal Code on the provision of health services to LGBT persons.

3. In addition to this submission, we have filed two affidavits. The first affidavit which is submitted by Mr Omumbwa seeks to provide the court with more context on the right to health, by providing a narrative of lived experiences of a person who is affected by the implementation of the provision and whose work seeks to provide access to services for men who have sex with men. The second affidavit is submitted by Professor Anand Grover, a former United Nations Rapporteur on the right to health. The affidavit provides international and comparative law and human rights standards on the right to health as it pertains to men who have sex with men.

STRUCTURE OF SUBMISSIONS

4. Without reharshing what is already set out in the affidavits, KELIN submissions will focus on the following issues:

   a. The lived experience of discrimination and stigma that prevents access to healthcare services;

   b. The link between criminalization and the provision of health services to men who have sex with men;

   c. The legal basis for claiming the right to health and State's obligation to provide the highest attainable standard of health to sexual minorities; and that

   d. The enforcement of sections 162 and 165 of the Penal Code leads to denial of health services and therefore a breach of the State's legal obligations.

A. THE LIVED EXPERIENCE OF DISCRIMINATION AND STIGMA THAT PREVENTS ACCESO HEALTHCARE SERVICES

5. Criminalization of same-sex sexual conduct has had adverse consequences towards men who have sex with men (MSM) in the context of HIV.[1] In his affidavit, Mr. Omumbwa has explained his lived experiences out of the implementation of Section 162(1)(a) and (c) and 165 of the Penal Code.

6. He has explained firstly, given that sometimes MSM have unprotected anal sex, their chances of contracting HIV and sexually transmitted infections (STIs) for gay men is higher. Studies have shown that unprotected anal intercourse is associated with a higher HIV transmission risk than unprotected vaginal intercourse. While anal sex is part of both heterosexual and homosexual sexual activity, much of the data on HIV transmission risk during anal intercourse comes from studies of men who have sex with men (MSM). [2] It is for this reason that MSM and transgender people have significant higher rates of HIV than the population as a whole in nearly every country.[3]

7. Secondly, he explains that owing to the criminalization of same sex sexual conduct, MSM fail to access treatment in good time in the event they contract STIs. They are reluctant to go to the hospital to access treatment for fear of revealing same sex sexual activity, which is criminal conduct under section 162(a) and (c) and 165 of the Penal Code. They fear being identified as gay and prosecuted as a result of the enforcement of these provisions. As a result,

[1]See UNAIDS, Report on the Global AIDs Epidemic 2010, Chapter 2: Epidemic Update 2010; AIDS Research, MSM, HIV, and the Road to Universal Access – How Far We Come? August 2008.

[2] See Leynaert B, Downs A.M and de Vincenzi I, "heterosexual transmission of human immunodeficiency virus: variability of infectivity through out the course of infection", European Study Group on Heterosexual Transmission of HIV, Am Journal Epidemiol, July, 1998; 148 (1) p 86-96

[3]Ibid n 1 p 6.

MSM are at higher risk of contracting HIV. Untreated STIs that last for a long time increases the risk of contracting HIV. [4] In *Judging During the Epidemic: A judicial Handbook on HIV, Human Rights and the Law;*[5] it is stated;

> *There is considerable evidence that having STI increases the risk of transmission of HIV, regardless whether the STI is in the HIV positive or negative partner. Several infections have been implicated, including herpes simplex virus (HSV), bacteria vaginosis, gonorrhea, chlamydia and vaginal candidiasis. The risk is generally in the range of 1.5 to 5 times higher than that seen in the absence of STIs.*

8. Thirdly, Mr. Omumbwa states that the access of MSM to health care is further impeded by the reproachful attitudes of health care professionals who are not trained to meet the needs of MSM, refuse to treat them altogether or respond with hostility when compelled to do so.

9. Fourthly, the impugned provision prevents MSM from accessing HIV testing and counseling services. He explains that most of the health care providers in most facilities are unwilling to provide HIV testing and counseling to a gay couple. Lastly, he explained about harassment faced by non-governmental organizations and peer educators who reach out to MSM to provide them with HIV prevention information thus undermining critical responses to the HIV and AIDS. MSM have also been subjected to physical and sexual violence yet the police have failed to investigate and prosecute whenever reports have been made.

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[4] See Galvin S.R and Cohen M.S, "the role of sexually transmitted diseases in HIV transmission" Nat Rev Microbiol, January 2004, 2(1) p 32-42.

[5] Publication by Joint United Nations Programme on HIV/AIDS (UNAIDS), 2013 p 25.

B. THE LINK BETWEEN CRIMINALISATION AND THE PROVISION OF HEALTH SERVICES TO MEN WHO HAVE SEX WITH MEN

10. Men who have sex with men (MSM) is a public health term that has come to define the sexual behaviour of men who have sex with other men. MSM covers a broad spectrum of sexual conduct and include men who do not regard themselves as gay or bi-sexual. The criminalization of same-sex sex creates an enabling environment for stigma and discrimination against MSM, which in turn reproduces vulnerability to HIV&AIDS for MSM. Criminalisation makes it difficult to provide information and carry out campaigns for prevention of HIV and other sexually transmitted infections.[6] According to surveys, gay men and other men who have sex with men often have extremely limited access to HIV prevention commodities, such as condoms, water-based lubricants, HIV education and support for sexual risk reduction.[7]

11. Service provision organisations are also hampered from reaching groups that may require service.[8] Governments are also not likely to promote HIV interventions that target MSM. As a result, MSM in countries where there is criminalization can sometimes be unaware of their risk of HIV, can be turned away from HIV services and are fearful of accessing HIV testing.[9] Key populations often have legal and social barriers which are related to their

[6] Human Rights Watch, Uganda: State Homophobia Threatens Health and Human Rights: Government Persecution Contributing to HIV Pandemic (August 23, 2007). http://hrw.org/english/docs/2007/08/22/uganda16729.htm. Amnesty International, Egypt: Spreading Crackdown on HIV Endangers Public Health: Rights Violations Drive Those in Need Underground (February 19, 2008). http://www.hrw.org/news/2008/02/14/egypt-spreading-crackdown-hiv-endangers-public-health.

[7] UN Joint Programme on HIV/AIDS (UNAIDS), The Gap Report, 2014, available at; http://www.refworld.org/docid/53f1e1604.html page 208

[8] International Guidelines on HIV/AIDS and Human Rights, UNHCR Res.1997/33, UN Doc.E/CN.4/1997/150 (1997)

[9] ibid UNAIDS, Gap report criminalization section

issues that enhance their vulnerability to HIV.[10] The consolidated guidelines advises that laws, policies and practices should be reviewed and revised where necessary, and countries should work towards decriminalization of behaviours such as same-sex activity and non-conforming gender identity and toward elimination of the unjust application of civil law and regulations who who have sex with men and transgender people.

12. Key populations (KPs) within the context of HIV in Kenya include: men who have sex with men (MSM); sex workers; people who inject drugs (PWUDS); and transgender persons. KPs are highlighted in the Kenya AIDS Strategic Framework as a priority population noting that legal cultural and social barriers related to their behavior increase their vulnerability to HIV.[11] Given this vulnerability the government is obligated to give them special attention to ensure they realize their right to health. As set out in affidavit of Prof. Grover, MSM sit in a unique position because a number of the populations are either criminalized, by laws such as the one that is the subject of the case, or not legally recognized and because of this they are both marginalized from society and vulnerable to HIV infection because of their marginalization.

13. The Kenya AIDS Response Progress Report indicates that the HIV prevalence among men who have sex with men stands at 18.2% and the service coverage for this population is 65%.[12] It is evident from the above that by criminalising consensual same –sex conduct, section 162 and 165 of the Penal Code are a weapon for police abuse and perpetuates negative and discriminatory beliefs towards same-sex relations and sexual minorities.

[10] Policy Brief: Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, 2016 update. Geneva: World Health Organization; 2017 (WHO/HIV/2017.05).
[11] Ministry of Health, Kenya Aids Strategic Framework 2014/2015- 2018/2019 p 10.
[12] Ministry of Health, Kenya AIDS Progress Report 2016.

14. Kenya recognises the need to provide health care services to those most at risk of HIV. In this regard certain groups have been designated as Key Populations in the HIV response. The Kenyan Government, in the Kenya AIDS Strategic Framework: 2014/2015-2018/2019[13] recognises that men who have sex with men are part of Key Populations because *inter alia* legal, cultural and social barriers related to their behaviour increase their vulnerability. The Strategic Framework notes that Key Populations contribute significantly to new infections, in particular, MSMs contribute 15%. It points out that factors driving new infections in the country include high risk sexual behaviour characterised by…denial and marginalisation of LGBT groups. In this regard, a key strategic objectives of the government includes reducing HIV related stigma and discrimination by 50%.

15. The Strategic Framework notes the data available shows that 24% of men who have sex with men were arrested or beaten up by police or city 'askaris' in the last six months.[14] In addition ,the Strategic Framework states that a priority intervention area is the improvement of county legal policy environment for protection of priority and Key Populations and people living with HIV.

16. The above shows that the Kenyan Government is aware that the LGBT community in Kenya is vulnerable to HIV infection and that there is a link between stigma and discrimination and the lack of access to treatment. The Framework provides that the strategic direction is to use human rights approach to facilitate access to services for persons living with HIV, Key Populations and other priority groups in all sectors. The Framework prioritises addressing the issue of violence against Key Populations through appropriate crises response mechanisms. It also aims to sensitise and engage communities and leaders such as religious leaders and elders on Key

[13] Strategic Guide for the country's response to HIV at both national and county level.
[14] As at 2014

Populations and HIV to reduce stigma and increase service uptake. There is also an intention to scale up Key Population friendly HIV care and treatment services with peer mobilisation and support.

17. Government programs set out above confirm that men who have sex with women are particularly susceptible to attracting HIV&AIDS and the government has made efforts to ensure that proper HIV intervention and prevention efforts are made available to such groups. However, with the existence of the criminalising law, the programs will not reach the affected people as this law is continuously a deterrent.

18. The above demonstrates that criminalization of consensual same-sex sexual acts leads to discrimination and stigma which discourages MSMs from accessing health services, obtaining treatment and accessing HIV prevention facilities. This in turn hinders the right of MSM to access the highest attainable standard of health.

C. THE LEGAL BASIS FOR CLAIMING THE RIGHT TO HEALTH AND STATE'S OBLIGATION TO PROVIDE THE HIGHEST ATTAINABLE STANDARD OF HEALTH TO SEXUAL MINORITIES

19. Constitution of Kenya, 2010 through Article 22(1) vests the power of enforcing the Bill of Rights to the Judiciary and indicates that any claim that a fundamental right has been denied, violated, infringed or threatened lies may be brought before the Court. The right to the highest attainable standard of health[15] is included in the Bill of Rights at Article 43(1) and the powers of the court to enforce fundamental rights established the justiciability of socio-

[15] Article 43(1) (a) of the Constitution of Kenya, 2010

economic rights beyond doubt.[16] In the case of *Kenya Society for the Mentally Handicapped v Attorney General and Others*[17] the court gave guidance on its role in enforcing the right to health as required by Article 22:

> *" . . the Court's purpose is not to prescribe certain policies but to ensure that policies followed by the State meet constitutional standards and that the State meets its responsibilities to take measures to observe, respect, promote, protect and fulfill fundamental rights and freedoms and to a party who comes before the Court"*

20. Our Courts have consistently demonstrated that they will enforce socio-economic rights and protect these rights through judicial determination. This underscores the Constitution's transformative agenda and the push beyond merely guaranteeing abstract equality and seeking to ensure substantive equality. The Court has not shied away from this role and has rendered the question on justiciability moot through its extensive jurisprudence on this right that we shall discuss in more detail through the submission.[18]

21. The right to health finds expression in Article 43(1)(a) of the Constitution; *"every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care*". In the case of ***P.A.O. & 2 Others vs Attorney General Petition No. 562 of 2012 (2012***), the High Court affirmed that the right to health is; *"a fundamental human right indispensable for the exercise of other human rights" and "[e]very human being is entitled to the enjoyment of the highest attainable standard of health*

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[16] Godfrey M Musila, Realizing the transformative promise of the 2010 Constitution and New electoral laws' in Godfrey M Musila (ed) *Handbook on Election Disputes in Kenya: Context, Legal Framework, Institutions and Jurisprudence* (2013).
[17] Petition No. 155A of 2011
[18] *PAO and others v Attorney General* Petition No. 409 of 2009; *Okwanda v Minister of Health Services and 3 others* Petition 94 of 2012; *L.N and 21 others v Ministry of Health and 2 others* Petition No. 218 of 2013; *W.J & another v Astarikoh Henry Amkoah & 9 others* Petition No. 331 of 2011; and *Maimuna Awour and another v the Attorney General and others* Petition No. 562 of 2012.

conducive to living a life in dignity." It further noted that the right to health encompasses;

> *"…not only the positive duty to ensure that its citizens have access to health care services and medication but must also encompass the negative duty not to do anything that would in any way affect access to such health care services and essential medicines."*

22. The above case also highlighted the nexus between the right to health and other fundamental rights and freedoms in the Bill of Rights such as the right not to be discriminated against on health status as established under Article 27(4) of the Constitution. This is further elaborated in Prof. Grover's expert affidavit before this Court.

23. The right to health is also recognized in regional[19] and international[20] law which by virtue of Article 2(5) and (6) of the Constitution forms part of the

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[19] Article 16 of the African Charter on Human and Peoples' Rights (African Charter) provides that; *"Every individual shall have the right to enjoy the best attainable state of physical and mental health."* In addition, the African Charter requires state parties to *"…take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick."* According to this article the obligation of the state to fulfil the right is immediate.

[20] The International Covenant on Economic, Social and Cultural Rights provides that State Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. It further provides that the steps to be taken by the States Parties to the present convention to achieve the full realisation this right shall include the prevention, treatment and control of epidemic, endemic, occupational and other diseases. General Comment 14 on Article 12 of the ICESCR strengthened the legal standards applicable to the right to health. It provides a detailed expression and interpretation of the content of the right to the highest attainable standard of health in Article 12. Three types of obligations of the right to health are highlighted:

a. Respect – the state must not interfere directly or indirectly with the enjoyment of the right to health, such as by denying or limiting equal access;
b. Protect – the state must take measures to prevent other parties from interfering with the right including the duty to adopt legislation to ensure equal access to essential health facilities, goods and services;

Kenyan law. Kenya is bound by the provisions of International Covenant on Civil and Political Rights (ICCPR)[21] and the International Covenant on Economic, Social and Cultural Rights (ICESCR).[22] By becoming party to the above treaties, Kenya assumed the obligations and duties under these treaties to respect, protect and fulfil human rights of all Kenyans irrespective of their sexual orientation.

24. Kenya thus has a constitutional and international law obligation with respect to ensuring that its citizens have access to the highest attainable standard of health. By having a law under section 162 and 165 of the Penal Code that has the effect of preventing access to health care for LGBT persons in Kenya, the state fails in its obligation to provide the highest attainable standard of health. The law in place is a deterrent for certain groups to access health care. Thus the State has failed in its negative duty not to do anything that would in any way affect access to health care services and essential medicines. Therefore, despite these obligations placed on Kenya under national and international law, and as the lived experience of Mr. Omubwa demonstrates, MSM do not

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c. fulfil – the state must adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realisation of the right.

[21] Acceded to by Kenya on 1 May 1972 which provides that each State Party to the Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights present in the Covenant without distinction of any kind, such as race colour, sex, language, religion, political or other opinion or social origin, property, birth or other status and no one shall be subjected to arbitrary unlawful interference with his privacy, family, home or correspondence, nor unlawful attack on his honour and reputation; and everyone has the right to the protection of the law against such interference or attack. The Human Rights Committee has recognised the right to non-discrimination on the basis of sexual orientation in relation to privacy.

[22] Acceded to by Kenya on 1 May 1972 and provides provides that the States Parties to it undertake to guarantee that the rights enunciated in the Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.[22] In General Comment No.20 the CESCR confirmed that the "other status" listed in ICESCR article 2(2) includes sexual orientation and gender identity

benefit from the protection afforded under the Constitution and international law.

25. Yogyakarta Principles 17 provides that everyone has the right to the highest attainable standard of physical and mental health, without discrimination on the basis of sexual orientation or gender identity.[23] Sexual reproductive health is a fundamental aspect of this right. The Principles set out state obligations geared at the protection of the right to enjoyment of the right to health by sexual minorities.[24]

26. The UN General Assembly Special Session (UNGASS) Declaration of Commitment on HIV&AIDS [25] adopted by all UN Member States emphasized the importance of "addressing the needs of those at the greatest risk of, and most vulnerable to, new infections as indicated by such factors as…sexual practices." The existence of section 162 and 165 of the Penal Code has the effect of against the LBBT community in Kenya in the provision of health services.

[23] The Yogyakarta Principles on the Application of International Human Rights Law in relation to sexual orientation and gender identity provide recommendations on how existing human rights statutes are to be applied in specific situations relevant to sexual minorities.

[24] States shall take measures including ensuring healthcare facilities, goods and services are designed to improve the health status of, and respond to the needs of all persons without discrimination on the basis of, and taking into account, sexual orientation and gender identity.

[25] Held on 25-27 June 2001.

D. THE ENFORCEMENT OF SECTIONS 162 AND 165 OF THE PENAL CODE LEADS TO DENIAL OF HEALTH SERVICES AND THEREFORE A BREACH OF THE STATE'S LEGAL OBLIGATIONS

27. To provide guidance on the normative content of the right to health, CESCR developed General Comment No. 14 on Article 12 [26] of ICESCR: [27] The Right to the Highest Attainable Standard of Health (Art. 12).[28]

28. The normative content of this right requires that: "*the right to health in all forms and at all levels contains the following interrelated and essential elements . . .* ", availability, accessibility, acceptability on quality. While General Comments are not binding they do have persuasive authority and gives states guidance as to the normative content of the rights enshrined in relevant instruments.[29] General Comment No. 14, arguably, forms part of the law in Kenya because its principles formed part of the binding dictum in *Maimuna Awour and another v The Attorney General and Others*[30] where the Court on the right to health the Court was guided by the Committee on Economic Social and Cultural Right (CESCR) and held that:

> *"In this regard, the CESCR states that ICESCR requires state parties to ensure that health services are available, accessible, acceptable, and of good quality. It interprets availability to encompass "not only...timely and appropriate health care but also...the underlying determinants of health such*

[26] Article 12 of ICESCR guarantees the right to the highest attainable standard of healt.

[27] Kenya has ratified this Convention and in terms of Article 2(6) of the Constitution this forms part of Kenyan law

[28] At paragraph 17 of General Comment No 14, the CESCR sets out what states need to do in order to realize Article 12 (2) (d) which requires states to take the necessary steps to achieve the full realization of the right to health, including '*the right to health facilities, goods and services'*. In addition, State Parties must ensure that public health infrastructures *provide public sexual and reproductive health services, that health providers are appropriately trained, and that health providers are trained to recognize and respond to the specific needs of vulnerable or marginalized groups*

[29] Blake C, 2008, Normative Instruments on International Human Rights Law: Locating the General Comment, Centre for Human Rights and Global Justice Working Paper No. 17, NYU School of Law, NW.

[30] Petition No. 562 of 2012.

as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions and access to health-related ... information."

Accessibility requires non-discriminatory access to health facilities, goods and services, "especially [for] the most vulnerable or marginalized sections of the population." In addition, accessibility also requires that health services be available and free from discrimination; they must be physically accessible; and they must also be economically accessible, that is they must be affordable."[31]

29. *Health services must be accessible to all without discrimination*[32]*:* The process of provision of health services must be transparently, participatory and accessible without discrimination. Facilities, goods and services must be accessible to all, especially the most vulnerable and or marginalized sections of the population in law and fact without discrimination on any of the prohibited grounds.[33] The principle of non-discrimination requires that even when sections of the population are marginalized in law this should not act as a barrier of access to health services. This is particularly significant within the context of MSM who are criminalized by Sections 162 and 165 of the Penal Code and various by-laws enacted by the principal municipal councils.

30. While there exists an enabling policy framework for protecting key populations criminalisation of key populations provides an enabling environment for the Kenya Government to refuse providing the services because of their criminal status. This is a position that is inconsistent with the

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[31] Supra at Paras 137-138.
[32] Para 12(b) of General Comment No. 14.
[33] The discriminated grounds are included in para 18 of General Comment 14 and include: sexual orientation; health status (including HIV and AIDS) or any other status.

principle of non-discrimination as discussed within the normative framework of this right.

Health services must be physically accessible[34]: Facilities, goods and services should be within safe physical reach for all sections of the population especially the most vulnerable and marginalized groups. Emphatic from this is the need to have access to services, which are within safe physical reach. This is particularly significant for men who have sex with men who because of their marginalization may not be able to access services (which may be within physical reach) that are specifically tailored for the general population because such access may not be safe either because of stigma they may fear potential criminal charges from exposing themselves.

31. Through the Global Fund to Fight Against HIV, Tuberculosis and Malaria, The President's Emergency Plan for AIDS Relief and a number of other donors, Kenya has invested in Drop-in Centers suited to provide services for men who have sex with men. This is however, a donor driven project with limited investment from the Government despite its obligation to protect this right.

32. Health services must be economically accessible (affordability)[35]**:** Payment for health services as well as well as the underlying determinants of health has to be based on the principle of equity and whether privately or publically funded should be affordable to all. Perhaps, one of the more significant aspects relating to men who have sex with men right of access to health. While incredible investment has been made in KP programmes these have been donor driven with little investment from the Kenyan Government and

[34] Para 12(b) of General Comment No. 14.
[35] Para 12(b) of General Comment No. 14.

even less indication that these are programmes they would be open to fund. This principle requires that not only health services but also underlying determinants are affordable to all.

33. *Underlying determinants of health:* The right is an inclusive right that is not only limited to access to medical care, it also obliges the state to focus on the underlying determinants of health. These determinants embrace a wide range of socio-economic factors that promote conditions in which people can lead a healthy life. Two of the relevant underlying determinants is the right to access information related to health education and information and the right to housing. Thus in interrogating whether or not the right to health has been protected or fulfilled the question becomes much broader. The Government is required to meaningfully engage in the underlying determinants, and identify those, which men who have sex with men are more likely to face discrimination in accessing such as housing. To do this a much broader conversation is needed in terms of accessibility one that cannot be limited to health services and must interrogate the accessibility of other rights. This is also true for the general population but because of their status within our society this more acutely affects men who have sex with men.

34. *Progressive realisation*: The right to health is subject to progressive realisation and resource availability. While this makes it clear that the right is no immediately enforceable in its entirety, it provides a framework for analysing whether the state is working towards a system that provides access to health systems that ensures access to all. In the context of HIV, these include the following:

32.1 Monitoring and reviewing laws and support and not hinder access to HIV support;

32.2 Inclusion of key populations in national treatment plans;

32.3 Inclusion of appropriate indicators and benchmarks in order to monitor whether the state is working towards the progressive realisation of the right, including disaggregation of data on appropriate grounds;

35. Criminalisation makes people fearful of disclosing their sexual orientation and sexual practices. Under reporting and inaccurate data has therefore lead to poorly designed or insufficient programmes increase the risk of HIV among homosexual and transgender persons. In addition, criminalization of same-sex activity runs counter to the implementation of effective educational programmes in respect of HIV prevention. Criminalisation dissuades gay men from seeking health services and it hampers the collection of data around same-sex activity and sexual practices as MSM may be reluctant to disclose their sexual orientation due to fear of the law. Fear of being identified as gay, which would lead to police- reporting, deters gay men from accessing health-care for fear of being prosecuted under the impugned provisions. MSM are reluctant to reveal same sex behaviour due to the fear of law enforcement agencies, keeping a large section invisible and unreachable and thereby pushing the cases of infections underground making it difficult for the public health workers to have access to them; this drives the activities of gay men and MSM underground thereby crippling HIV&AIDS prevention efforts.

36. *Non-retrogression.* Current level of enjoyment of rights must be maintained and measures lowering the enjoyment are not permitted. Criminalisation makes the enjoyment of the right reliant on the whim of policymakers and political leadership.

Conclusion

37. HIV prevention efforts and programs are impaired by discriminatory attitudes towards men who have sex with men due to the existence of the criminalising law. For as long as the criminalising law exists, any government programmes designed to respond HIV will not be adequate to provide health services to men who have sex with men. In any event such interventions are not sustainable because a decision to provide health services targeted at MSMs can be overturned at any stage on the basis of section 162 and 165 of the Penal Code. Therefore, the law must change in order to facilitate access to the highest standard of health care for all Kenyans, including LGBT persons.

38. Based on current evidence before the court, if same sex sexual relations remain criminalized, it is likely that HIV interventions for MSM will continue to be inadequate. Consequently, MSM will continue to be marginalized from health services, and HIV epidemic will escalate.

39. We support the Petition and urge the Court to grant the orders sought.

Dated at **NAIROBI** this day of 2018

CAROLENE KITUKU

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