HEALTH AND HEALTHCARE EXPERIENCES OF PEOPLE LIVING AND WORKING IN THE STREETS OF NAIROBI COUNTY.

A Survey conducted by the Undugu Society of Kenya
in collaboration with Nairobi City County Health Sector
and supported by the Commonwealth Foundation

MAY 2023

SOCIETY
UNDUGU

USK is child and youth centered and has been implementing development interventions focusing on; Rescue, Rehabilitation and Re-integration (RRR) of children and youth living or working in the streets, their families, as well as socio-economic empowerment of poor urban and rural communities in Kenya.

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Francis Kiilu

Francis Kiilu (Chair-Board of Directors**)**

ABREVIATIONS

ART:	Anti-Retroviral Therapy
CHVs:	Community Health Volunteers
FBOs:	Faith Based Organizations
FGDs:	Focus group discussions
HIV & AIDS:	Human Immunodeficiency Virus & Acquired Immuno-Deficiency Syndrome
ICESCR:	International Covenant on Economic, Social and Cultural Rights
KII:	Key Informant Interviews
MLAWS:	Mothers Living and Working on Streets
NGOs:	Non-Governmental Organizations
PEP:	Post-Exposure Prophylaxis
PLAWS:	People Living and Working on Streets
PrEP:	Pre-Exposure Prophylaxis
SDGs:	Sustainable Development Goals
SPSS:	Statistical Package for Social Sciences
STIs:	Sexually Transmitted Infections
THAF:	Total Health Advocacy Foundation
UDHR:	Universal Declaration of Human Rights
USK:	Undugu Society of Kenya
VCT:	Voluntary Counseling & Testing
WHO:	World Health Organization

UNDUGU SOCIETY OF KENYA

Undugu Society of Kenya is headquartered in Westlands, Nairobi, with field offices in Dandora. It has two more field offices and facilities in the Counties of Kisumu and Kajiado. It was established as a non-profit making organisation in 1973 by the late Father Arnold Grol, a Dutch priest, resident of Kenya. He founded the organization after he observed a growing disturbing phenomenon of children living and working in the streets of Nairobi and its environs. USK is child and youth centered and has been implementing development interventions focusing on; Rescue, Rehabilitation and Re-integration (RRR) of children and youth living or working in the streets, their families, as well as socio-economic empowerment of poor urban and rural communities in Kenya.

USK runs a children's centre that provides shelter and care for vulnerable children before they are reintegrated with their families, if at all. To add value to the lives of USK's beneficiaries the society implements networking, lobbying and advocacy strategies both at County and National level to ensure the protection and care of the children and youth therein.

In delivering its mandate, as provided for in the 2023-2027 Strategic Plan, USK is implementing a project on 'Health security for persons living and working on the streets of Nairobi in Kenya', which is supported by the Commonwealth Foundation. **The Commonwealth Foundation is an intergovernmental organisation established by Heads of Government in support of the belief that the Commonwealth is as much an association of peoples as it is of governments. It is the Commonwealth agency for civil society; a unique, stand-alone organisation established by, funded by, and reporting to governments.** The Foundation is dedicated to strengthening people's participation in all aspects of public dialogue, to act together and learn from each other to build democratic societies.

EXECUTIVE SUMMARY

BACKGROUND

Homelessness is a growing concern affecting many people worldwide. Individuals and families experiencing homelessness collectively referred in this study as People Living and Working on the Streets (PLAWS) are vulnerable in terms of health and underutilize health services. People living and working on the street face many barriers and challenges in pursuance of health care, while their attitudes toward seeking health care services are shaped in part by their own or their colleagues' previous encounters with health care providers. Despite being a global problem, not much is known about the range and breath of literature exploring health problems and health care service utilization among PLAWS in Africa. The dearth of studies on this issue in Kenya is disempowering, yet homelessness is phenomenon being experienced in most of the 47 counties.

OBJECTIVES

The research had two main objectives. First, to examine how people living and working on the streets experienced healthcare services based on past encounters with healthcare providers and how such interactions influenced their perceptions. Secondly, to examine how state and non-state health care service providers handle people living and working on the streets whenever they seek various health care services.

DESIGN

The sampling method we adopted for this study was purposive sampling and the semi-structured interviews were used for data collection. The sample type was homeless street people, referred to in this study as People Living and Working on the Streets (PLAWS) and health care service providers. We targeted to reach a sample size of 280 (75 healthcare givers, 20 key informants and 185 PLAWS). However, we reached 66 health care givers, 18 Key informants and 163 PLAWS). Qualitative content analysis of in-depth interviews with select People Living and Working on the Streets and Health Care Service Providers.

APPROACH

Interpretive content analysis was performed using iterative stages of inductive coding. Interview transcripts were analysed using Buber's philosophical conceptualization of ways of relating as "I-It" (the way persons relate to objects) and "I-You" (the way persons relate to dynamic beings).

RESULTS

Most participants perceived their experiences of unwelcomeness and repulsion as acts of discrimination. Living and working on the streets besides allegations of lowly social class were most cited as the perceived basis for discriminatory treatment. Most of the respondents reported intense emotional responses to unwelcoming experiences, which negatively influenced their desire to seek health care in the future. Further, some of the respondents reported unparalleled fear in seeking health care as they feared being diagnosed with life-threatening diseases like tuberculosis, HIV, or cancer. Respondents' descriptions of unwelcoming health care encounters were consistent with "I-It" ways of relating in that they felt dehumanized, ignored, not listened to, or disempowered. Welcoming experiences, especially to lactating mothers, were consistent with "I-You" ways of relating, in that patients felt valued as a person, truly listened to, or empowered.

CONCLUSIONS

Even though national and county governments have made efforts to provide health services including primary care, emergency services, maternal care, and mental health service, such have

not reach everyone, nor satisfied acceptable standards. As such, the health system in Kenya is generally inadequate, and has only to a small extent facilitated equitable and sustainable access, if compared to functional health care infrastructure in other jurisdictions. Health services are mostly accessed by out-of-pocket expenses which shuts out those unable to pay. Without targeted health policies and programmes, PLAWS will continue to be vulnerable, owing their experience owing various intersecting challenges. Three main health challenges were identified as: physical health problems; mental health problems; and healthcare services utilization.

Homeless persons' perceptions of how healthcare system treats them is seen in the dichotomy of repulsion and accommodation. These physical encounters with healthcare personnel largely informs, forms and reforms the attitude and behaviour of PLAWS in judging or evaluating the responsiveness of the healthcare system to those considered vulnerable and weak in society. Buber "I-It" and "I-thou/You" concepts are potentially useful aids to health care providers who wish to understand how receptive or repulsive interactions are engendered and fostered. Similarly, Martha Nussbaum Capability theory offers insights into ensuring every human being regardless of their status in society flourishes.

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1.0 INTRODUCTION

1.1 POPULATION LIVING AND WORKING ON THE STREETS (PLAWS)

The presence of People Living and Working on the Street (PLAWS) is a social phenomenon continuing to assume new expressions and dimensions in contemporary societies, particularly urban areas. This phenomenon has gripped Nairobi as well which accounted for 33% of all PLAWS in 2018, due to various and unique reasons. PLAWS who are excluded and marginalized seek central regions of cities or dumping sites to live in because these places generally offer survival pathways and opportunities to the many homeless, such as commercial areas or areas with a greater concentration of services, the great circulation of people and the few residences.

Poverty, structural unemployment, rural-urban migration, family conflicts, drug and, substance dependency and peer pressure, are assumed by many policy makers, commentators and larger community to be among the major reasons that contribute to the growing number of PLAWS. There are certain experiential characteristics that commonly manifest across and among PLAWS, which include inability to afford decent residence, coupled with incapacity to fulfill basic needs of man. Such exclusion has relegated them to a life of indigence, and absolute poverty.

In addition to the state of indigence and homelessness, this group continues to experience inadequacy in accessing their socio-cultural and economic rights as espoused at Article 43 of the Constitution, including inability to avoid hazardous, unhygienic, and unsustainable income seeking environments. This scenario has affected their identity, security, physical and emotional well-being, feelings of belonging and roots. The lack of housing besides being a major challenge faced and experienced by PLAWS, it is foundational in creating opportunities to access other important communal and individualized socio-economic engagements such as belonging, systemic inclusion and social support system to enhance identity, security, physical and emotional well-being, and understanding of ancestry. There is little homogeneity in this group, since the main difference between its components is related to life trajectories, length of stay on the street, survival strategies adopted, gender relations and dynamics of the inhabited territory itself.

For a considerable period, successive governments in Kenya have not been deliberate in sorting out the mess of street communities. There has been noticeable absence of policy and programme. Up to and until 2018, when national census was carried out and some generalised social protection policy put in place, only street connected communities have consistently been mentioned as an at-risk group.

PLAWS sometimes do not have precise chronological time of staying on the street. However, going to the street is almost always motivated by an unforgettable event for those who lived it, often rarely spoken about. If length of stay on the streets is considered a parameter, alongside the relationship with this context of life and the family ties, then PLAWS can be classified into three groups, as a correspondence to their situation on the streets. The categories are staying on the street (circumstantially), being on the street (recently), and being on the street (permanently). PLAWS presence on the streets can be grouped into some generational paradigm, with those who originally traveled and settled being the first generation and their families taking up the next. Children born of this reality only associate with the street as their home.

For a considerable period, successive governments in Kenya have not been deliberate in sorting out the mess of street communities. There has been noticeable absence of policy and programme. Up to and until 2018, when national census was carried out and some generalised social protection policy put in place, only street connected communities have consistently been mentioned as an at-risk group. While there are several social protection policy and frameworks, there are no known specific mechanisms to provide healthcare service in public policies focused on this segment, in part because no state anticipates its development agenda to produce such unfortunate demographics and attendant outcomes. The country has generalized its approach to protection and promotion of socio-economic rights, despite the 2014-2030 Kenya Health Policy highlighting principles of non-discrimination in its objectives to improve the health and healthcare services for clients, such as:

a) Equity in distribution of health services and interventions.
b) Public participation, in which a people-centred approach and social accountability in planning and implementation is emphasized.
c) Social accountability, by healthcare service delivery systems being reoriented towards the application of principles and practices of social accountability, including reporting on performance, creation of public awareness, fostering transparency, and public participation in decision making on health-related matters: and
d) Inclusion, which is part of each of the six policy objectives, particularly assigning some strategies to address access and utilization of healthcare service for hard-to-reach communities, and geographies, the key populations, marginalized, people living with disabilities, the elderly, and the indigent.

Owing to the generalization, PLAWS lack and suffer serious social and economic vulnerability, harm, and difficulties in accessing health care services. This vulnerability is exemplified in persistent stigma and prejudice.

Nonetheless, the Constitution of Kenya, 2010 in tandem with relevant human rights driven international legal and policy instruments are binding and require the state to respect, protect, promote, and fulfil a whole gamut of PLAWS' rights. Even then, it is acknowledged that realising health rights of PLAWS remains a daunting task, for a number of reasons. This is because homeless tend to have a high burden of illness and are predisposed to high risk to diverse infections besides increased risk of premature death. Similarly, they do not have a fixed aboard and thus may miss certain critical immunizations and vaccinations that tend to use household as a unit of focus.
This exploratory study sought to delineate the health-related challenges faced by this population and assessed the knowledge, attitudes, and behavior of health service providers toward them. It further seeks to highlight the opportunities that a differentiated health policy and practice may bring to alleviating them some of health-related challenges.

2.0 THE LEGAL POLICY IMPERATIVES

The right to health is a socio-economic right recognized under international human rights law. It is recognized as a right to standard of living under Article 25 of the Universal Declaration of Human Rights (UDHR). Article 12 of International Covenant on Economic, Social and Cultural Rights (ICESCR), states that, the States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

Chapter Four of the 2010 Constitution of Kenya provides a normative framework for the recognition, protection and promotion of fundamental, constitutional, and human rights and freedom. Article 19 (1) reaffirms the importance of this Chapter and consigns the Bill of Rights as an integral part of Kenya's democratic state and a framework for all its social, economic, and cultural practices.

This Chapter is, according to Article 19 (2), based on the fundamental requirement to preserve the dignity of individuals and communities besides promoting social justice and the realization of the potential of all human beings. Article 19, Clause (3) and paragraph (b) further recognizes the rights and the freedoms included in the Bill of Rights as not a numerus clausus (although they are comprehensive), but that other rights may also be recognized in so far as they are not inconsistent with the Bill of Rights.

The United Nations Sustainable Development Goals (SDGs) number 3 targets good health and well- being for all persons. Specifically, target 3.8 aims to achieve universal health coverage, access to quality essential health-care services and essential medicines and vaccines for all. The World Health Organization (WHO) recognizes health as a human right of every human being and legal obligation on states to ensure access to timely, acceptable, and affordable health care.

The right to health is intended in law and policy to be enjoyed without discrimination on any grounds. In Kenya, health is recognized as a fundamental human right and is guaranteed by the 2010 constitution. Article 43(1) provides that every person has a right to the highest attainable standard of health which includes the right to health care services, including health care. Further under the Kenya Health Policy 2014-2030, despite absence of specific programme, or mechanism, there is recognition of the marginalized, vulnerable and hard-to-reach groups and communities.

2.1 Overall Objective of the Study

To examine the health and healthcare experiences faced and lived by People Living and Working on the Streets (PLAWS) of Nairobi County, and how they characterize their perceptions of such interactions.

2.2 Specific objects of the Evaluation

i) To determine perception of PLAWS on health service providers
ii) To establish perception of PLAWS on health policies and practices
iii) To establish the role of national and county governments in the realization of PLAWS health rights
iv) To make recommendations on how best to address emergent social vulnerabilities and difficulties in realization of health rights for PLAWS

2.3 Target Population and Area

According to the 2018 National Census of Street Families, there are a total of 46,639 street persons in Kenya, with Nairobi hosting 15,337, of whom sixty-six percent (66%) are male and thirty-four percent (44%) are women. Being home to thirty-two, point nine percent (32.9%) of the PLAWS, makes Nairobi a good starting point to understand their health and healthcare issues and experiences, especially in identifying gaps and opportunities.

The research therefore targeted Nairobi County, in part as the capital city and political centre of Kenya, but significantly for likely provision of diverse street connected scenarios, considered a bedrock for comprehensive findings and realistic recommendations seeking to influence holistic policies on issues affecting people living and working on the streets.

Seven constituencies were randomly selected. These are Mathare, Kasarani, Roysambu, Kamukunji, Embakasi North, Kibra, and Starehe constituencies. The seven constituencies were selected due to resource constraints and had a perfect mix of different PLAWS that was deemed to be representative enough.

The right to health is intended in law and policy to be enjoyed without discrimination on any grounds. In Kenya, health is recognized as a fundamental human right and is guaranteed by the 2010 constitution. Article 43(1) provides that every person has a right to the highest attainable standard of health which includes the right to health care services, including health care.

46,639

Total number of street persons in Kenya

15,337

Total number of street persons in Nairobi

66%

Percentage of male street persons

44%

Percentage of women street persons

3.0 DESIGN AND METHODOLOGY

3.1 The design
The preliminary survey was a cross-sectional survey. It primarily sought to understand how generalized approach creates intersectionality of health rights violations amongst PLAWS.

3.2 The Methodology
A mixed method approach was used in collecting, analyzing, and interpreting data. This approach was advantageous as it provided a wider spectrum in understanding complex problems such as the health rights violation of the PLAWS.

Quantitative tools, semi-structured questionnaires, were utilized to collect data on health rights awareness and perceptions of the violations of the same health rights by the people living and working on the streets.

The qualitative data was collected using Key Informant Interviews (KII), Document Analysis and Focus group discussions (FGDs). Key informant guides and semi-structured questionnaires were administered to the respondents. The KII sought to get information from health care givers, community health workers, social workers and other community leaders like paralegals and local administrators.

Observation guide was utilized to establish the causal relationship among a group of variables under study, while Statistical Package for Social Science (SPSS) was used for transcription and analysis of the responses.

3.3 Research Approach
The survey employed a mixed qualitative and quantitative approach in the collection, analysis, and interpretation of data. The quantitative method was used to collect data on health services' accessibility affordability and relevance, health rights awareness and violations from PLAWS and HSPs.

The qualitative method was deployed in key informant interviews.

3.4 Sample Size
The research targeted a population of 280 respondents broken down as follows; 75 healthcare service providers, 20 key informants and 185 PLAWS (50 youths, 45 lactating mothers, 45 children, 45 adults).
Healthcare service providers were qualified as

- Local health Centres- dispensaries and up to level 3 hospitals run by the county government.
- County government level 4 and 5 hospitals
- Referral hospitals
- Private health centres
- Local Health NGOs/FBOS

People Living and Working on the Streets (PLAWS) were defined as rough sleepers or roofless people. They were categorized as:

- Children through their caregivers, parents and guardians- under the age of 18
- Mothers- lactating or not
- The youth- between ages 18-35
- Adults- above 35 years

Key informants were to be drawn from among the community and included local administration, county health policymakers, community health workers, social workers etc.

A total of 245 respondents were interviewed. They include 66 health service providers, 18 key informants and 163 PLAWS (23 mothers, 43 children, 53 youths, 44 adults). This means that we reached 87.5 per cent of our targeted respondents. The biggest variance was with the category of mothers.

3.5 Research Instruments

An administered questionnaire was the primary data collection tool for the study.
PLAWS were asked to provide general demographic information, physical accessibility to health centres, health rights awareness and health rights violations, if any. Health Service Providers were interviewed on the relevance of their services to PLAWS, healthcare issues common to PLAWS by category and intervention mechanisms needed to mainstream PLAWS healthcare needs. Key Informants Interviews were used to isolate issues around health rights challenges and PLAWS health rights violations with emphasis on indicators of violation, reporting mechanisms and policies against such violations.

3.6 Data Analysis

SPSS was used in the transcription and analysis of the responses.

The qualitative data was collected using Key Informant Interviews (KII), Document Analysis and Focus group discussions (FGDs). Key informant guides and semi-structured questionnaires were administered to the respondents. The KII sought to get information from health care givers, community health workers, social workers and other community leaders like paralegals and local administrators.

4.0 FINDINGS

4.1 Mothers

Twenty-three mothers were interviewed against a target of 45 respondents. Of these, 22 had lactating children while one mother was not lactating. The interviewed mothers, had originally, in setting foot to the city of Nairobi, come from 11 counties across the country. Murang'a and Kiambu led with 17.4 per cent closely followed by Kisumu and Nyeri with 13 per cent, and Makueni coming third with 8.7 per cent. Nairobi, Embu, Mombasa, Kericho, Homa Bay and Nyamira each contributed 4.35 per cent.

Most (73.9 per cent) of the mothers interviewed in the study had been on the streets for over six years. This is because 39 per cent had been on the streets between 6-10 years, 8.7 per cent had been on the streets between 11 and 15 years while 26 per cent had been on the streets for over 15 years.
Sixty-five per cent of the mother were on the streets because of family reasons while 8.7 per cent were on the streets because of one following reasons: poverty, peer pressure, voluntary, born in the streets.

Most of the mothers (60.87 per cent) indicated that they were users of different drugs and substances among them bhang, cocaine, and sniffing glue. 17.4 percent of the mothers were non-users while 21.74 per cent were reformed (that is they were drug-users/abusers before but have since stopped). Most of the women interviewed have had a miscarriage or knew one of their colleagues on the streets who had had a miscarriage. According to information from health care givers, most mothers living or working on the streets could not relate their use/abuse of drugs with miscarriage or low-birth weight for their children.

4.1.1 Distribution of mothers by age

The data show that most of the mothers (48 per cent) were aged between 26-35 years.
The distribution of mothers by age bracket is summarized in the pie-chart below (Figure 1).

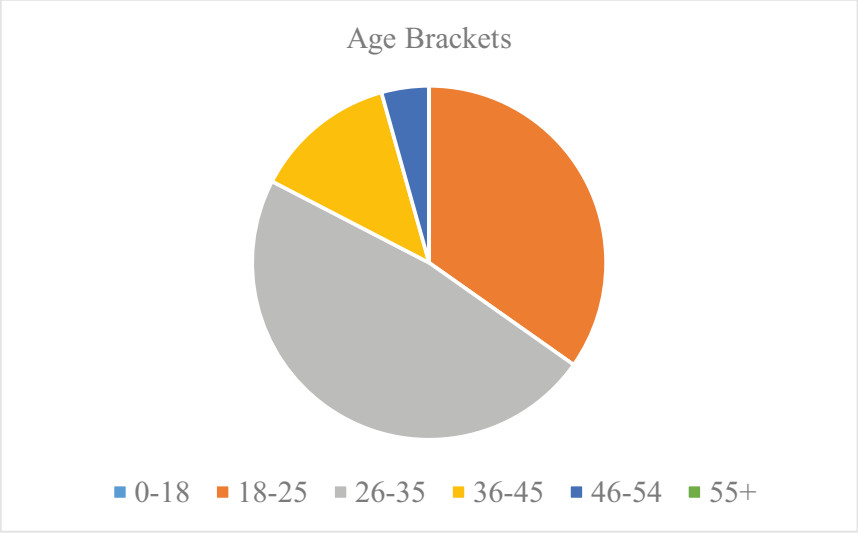

Figure 1: Age distribution of female respondents

4.1.2 Breastfeeding data with education levels of mothers

We sought to assess whether education levels of mothers living and working on the streets (MLAWS) had a correlation with breastfeeding and the vaccination status of their children.

The study had 23 respondents in the category of mothers. Data shows that 22 were lactating mothers. Only one mother did not have a lactating baby. All the mothers indicated that they tended to breast feed their children for over a year. But none of them breast fed for over 2 years.

Table 1: Mothers lactating

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Breastfeeding	22	95.7	95.7	95.7
Not breastfeeding	1	4.3	4.3	100.0
Total	23	100.0	100.0	

Table 2: Crosstabulation of breastfeeding data with education levels of mothers

Baby * Education Level Crosstabulation

Count

	Education Level			
	Non	**Primary**	**Secondary**	**Total**
Valid Breastfeeding	2	11	9	22
Not breastfeeding	0	0	0	1
Total	2	11	10	23

All mothers had at least primary education and reported having had their children vaccinated. A few of them, 38 per cent, also indicated that they had received Tenanus-Diptheria during their pregnancy. Most of them indicated that if they had to visit a health facility, they tended to go to public health clinics, dispensaries as private hospitals discriminated against them by requiring pay for services.

However, most of them seemed unaware of the need nor had they received other vaccines like for polio, cholera, typhoid, influenza, yellow fever, smallpox, Hepatitis B, Human Papilloma Virus (HPV) and Meningitis. When asked if they had teenage girls who may need to receive HPV vaccines, most

responded in affirmative but indicated that such vaccines are only likely to cause infertility and complicated pregnancies.

This is indicative of the role which education plays in informing PLAWS of their or their dependents health needs.

4.1.3 Street occupation and income

There were three clearly defined occupation options, namely, begging, shoe-shining, carrying small items and others (where the respondent would state their occupation). Occupations captured under 'other' were casual work, food vending and garbage collection. 14 mothers listed begging, 4 listed carrying small items while 5 stated other as their occupation. No response was returned by shoe-shining. The percentage distribution of occupations is captured in Figure 2 below.

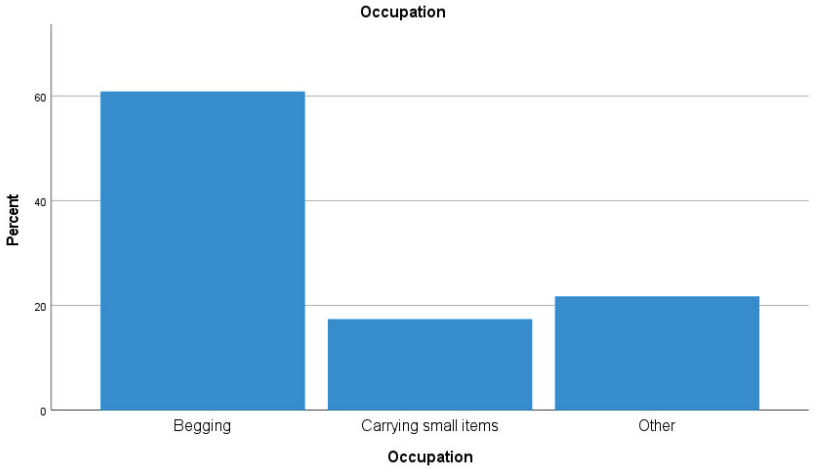

Figure 2: Percentage distribution in different Occupations

Occupations of street mothers are indicative of low pay and a consistent sign of income insecurity. Most lack a steady source of income as they make just about ksh 100-499 which is not consistent daily. As a result, most are unable to cater for their and their children's health needs effectively.

4.2 Adults

The study had 44 (22 male and 22 female) adult respondents. The 44 adults interviewed originally came from 13 counties across the country namely: Nairobi (9), Kiambu (8), Nyeri (6), Kitui (4), Kisumu (3), Muranga (3), Siaya (2), Kakamega (2), Homa Bay (1), Kisii (1), Nakuru (1) and Vihiga (1).

4.2.1 Distribution by age bracket

The adults were categorized by age groups to inform the assumption that long years on the streets meant greater exposure thus value of the information obtainable.

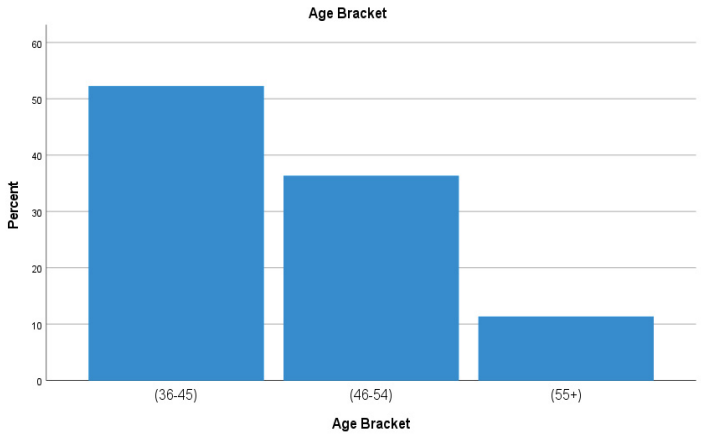

Figure 3: Distribution by age bracket

52 per cent of adults PLAWS interviewed were between ages 36-45, 37 per cent were between ages 46-54 while only about 11 per cent were above 55 years. This may be indicative of low life expectancy or migration back to rural homes as they age, but more investigations need to be done.

4.2.2 Level of education

The level of education among adult PLAWS could inform their awareness of health rights and the possibility of instructing them on reporting mechanisms. Such knowledge can then be passed by them to others in their communities. See Figure 4 below.

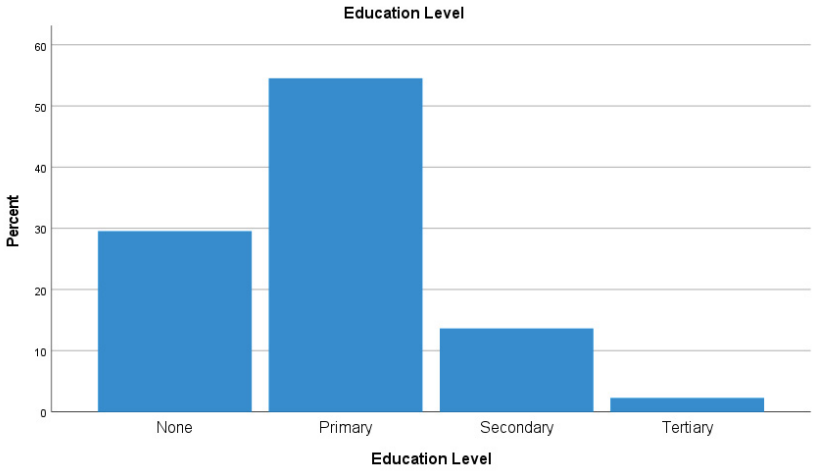

Figure 4: Levels of Education

The data shows that only about 29 per cent of the elderly had received no form of formal education at all. That 70 per cent of the adult respondents had at least primary education makes it possible to share health related information to PLAWS.

Most (95.45 per cent) of the adults interviewed in the study had been on the streets for over six years. This is because 15.9 per cent had been on the streets between 6-10 years, 6.8 per cent had been on the streets between 11 and 15 years while 72.8 per cent had been on the streets for over 15 years.

54.5 per cent of the adults were on the streets because of family reasons. However, the population of women on the streets because of family reasons was slightly higher than men (59.1 per cent compared to 50 per cent). An estimated 15.9 of the adults interviewed in the study were forced to be on the streets. An estimated 6.8 per cent were on the streets because of one following reasons: poverty, voluntarily or were born on the streets. The remaining 9.1 per cent could not adduce any reason for being on the streets.

4.2.3 Distribution by drug usage

Following on the observation on age group above, the drug use and rehabilitation history of adults was sought to highlight effectiveness of rehabilitation procedures and impact of drug-use on health tendencies.

Drug Usage				
	Frequency	**Percent**	**Valid Percent**	**Cumulative Percent**
Valid User	22	50.0	50.0	50.0
Non-user	12	27.3	27.3	77.3
Reformed	10	22.7	22.7	100.0
Total	44	100.0	100.0	

Table 3: Drug use and Abuse

Half of the adults interviewed in the study indicated that they were users and abusers of different drugs/substances including bhang, cocaine, and sniffing glue. 27.3 percent of the elderly were non-users while 22.7 per cent were reformed (that is they were drug-users before but have since stopped).

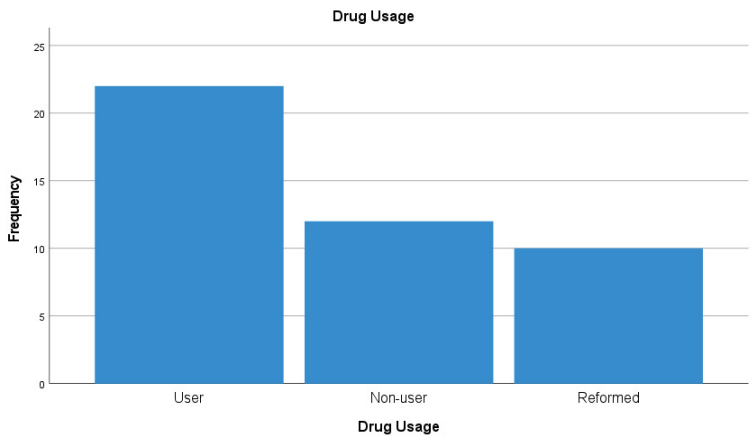

Figure 5: Frequency of drug usage/abuse

The bar graph above shows that the largest percentage, 50 per cent are active drug users, pointing to the fact that the situation is dire and needs a quick intervention.

4.2.4 Health status in the past 6 months

The table below shows the adults' health status in the last six months. An estimated 54.5 per cent of the adult respondents were taken ill, at least, in the last six months. This clearly indicates that over half of the adults have fallen ill and remain susceptible to contracting different diseases lest proper health programmes targeting the PLAWS are developed and implemented.

Table 4: Sick in the past six months

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Yes	24	54.5	54.5	54.5
No	20	45.5	45.5	100.0
Total	44	100.0	100.0	

A cross-tabulation analysis further reveals that 61.9 per cent of women have at least fallen sick in the last six months. The percentage is way above that of men who have fallen sick in the last six months and who are at 47.83 per cent. Therefore, this study reveals that women working and being homeless are more susceptible to diseases than men.

Table 5: Gender * Sick in the past six months Cross tabulation
Count

	Sick in the past six months		
Gender	**Yes**	**No**	**Total**
Male	11	12	23
Female	13	8	21
Total	24	20	44

4.2.5 Occupations and incomes

The correlation between occupation types and incomes of the adults was also tested. Data showed that 68 per cent of adult PLAWS engaged in garbage collection and sorting as consistent but not daily occupation, earning between Ksh 100-499 per day.

An estimated 18 per cent were cart pushers and carriers of small items, while 9 per cent engaged in small trade, both groups earning between ksh 500-999 per day.

Occupations and incomes data indicate high prevalence of poor work and exposure to health hazards, alongside the low income translating to inability to take care of rising cost of health challenges. This indicates the need for policy interventions, programmes and mechanisms to guarantee PLAWS free medical care.

4.3 Youth

Fifty-three youth were interviewed in this study with 40 being male and 13 being female.

4.3.1 Reasons for being on the streets

64.15 per cent of youth PLAWS listed family reasons as having majorly contributed to their moving to streets. Attempts to rehabilitate and repatriate youth PLAWS should therefore be premised on identifying and resolving those family issues.

	Frequency	Percent	Valid Percent
Birth	3	5.66	5.66
Forced	2	3.77	3.77
Voluntary	4	7.55	7.55
Peer influence	5	9.43	9.43
Poverty	3	5.66	5.66
Family reasons	34	64.15	64.15
Do not know	2	3.77	3.77
Total	51	100.0	100.0

Table 6: Reasons for being on the street

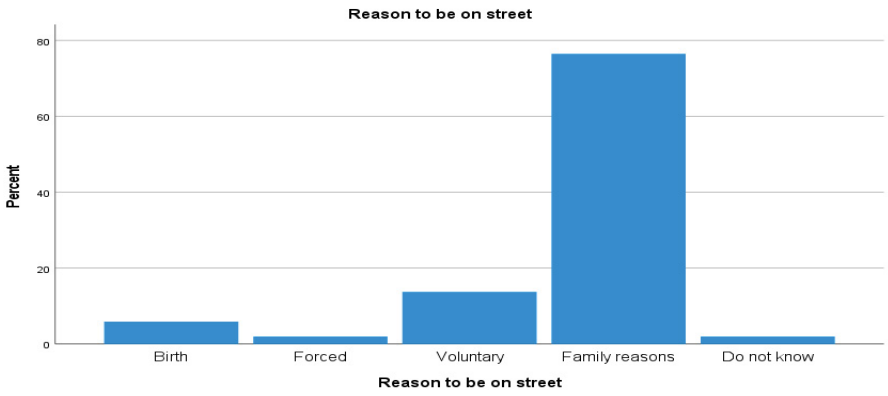

Figure 6: Reasons for being on the streets

The youth interviewed originally came from 14 counties across the country. These are Nairobi (10), Muranga (8), Machakos (7), Kiambu (5), Homa Bay (4), Nyeri (3), Meru (3), Nakuru (3), Kakamega (2), Vihiga (2) and one each from Kisii, Uasin Gishu, Pokot and Busia.

Most (75.5 per cent) of the youth interviewed in the study had been on the streets for over six years. This leaves only 24.5 per cent of the youth interviewed in the study who had been on the streets for five years and below. An estimated 28.3 per cent had been on the streets for between 6-10 years while 18.7 per cent had been on the streets between 11-15 years and another 28.3 per cent had been on the streets for over 15 years.

An estimated 64.15 per cent of the youth were on the streets because of family reasons. The second biggest group, 9.43 per cent, were on the streets because of peer influence while 7.55 per cent were voluntarily (they made a personal choice) on the streets. The others were on the streets for varied reasons, among them birth (5.66 per cent), poverty (5.66 per cent), forced (3.77 per cent). An estimated 3.77 per cent of the youth could not find a reason for their being on the streets.

Most of the youth (52.83 per cent) indicated that they were users of different drugs among them bhang, cocaine, and sniffing glue. An estimated 13.20 percent of the youth were non-users while 33.96 per cent were reformed (that is they were drug-users/abusers before but have since stopped)
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4.3.2 Distribution by gender

Data shows that there were more male (74.5 per cent) than female (25.5 per cent) youth PLAWS respondents. This indicates that young boys are more predisposed to homelessness than girls.

Table 7: Gender representation of the youth respondents

	N	%
Male	40	75.47%
Female	13	24.52%
Total	53	100%

4.3.3 Health status in the past 6 months

An estimated 65.79 per cent of males were taken ill at least in the last six months. In the same period, 69.23 percent of females were taken ill. This still shows an almost similar likelihood of illness to both sexes, thus interventions to youth health needs do not need to be differentiated based on this parameter.

Table 8: Health status past 6 months * Gender Crosstabulation
Count

		Gender		
		Male	**Female**	**Total**
Health status past 6 months	Taken ill	12	9	34
	Not taken ill	8	4	17
Total		20	13	51

4.4 Children

Forty-three childcare giving adults were interviewed target of 45 respondents, regarding the status of their children's health and attendant response.

Those interviewed originally came from 9 counties across the country namely: Nairobi (17), Kiambu (7), Muranga (3), Machakos (4), Kitui (2), one each from Kisumu, Vihiga, Kericho and Kakamega. The caregivers had three children whose original homes (counties) remained unknown.

Most (60.47 per cent) of the caregivers interviewed in the study indicated presence with the children on the streets for between one year and five years. Another set of 27.9 per cent had been homeless between 6-10 years while 9.3 per cent had been on the streets between 11 and 15 years. An estimated 2.33 per cent have been on the streets for over 15 years.

An estimated 44.2 per cent of the children interviewed were on the streets because of family reasons while 18.6 per cent were born on the streets. Other push factors causing children to go to the streets were: personal choice /voluntary (11.63 per cent), forced (9.3 per cent), and poverty (2.32 percent). An estimated 13.95 per cent did not cite any reason for their homelessness.

Caregivers indicated most children (67.44 per cent) to be users and abusers of different drugs that largely comprised of bhang, cocaine, and sniffing glue. 18.6 per cent of the children were non-users while 13.95 per cent were reformed (that is, they were drug-users/abusers before but have since stopped).

It was indicated that boys tended to be prone to drug use and abuse compared to the girls. This, from the care givers response meant 58.6 per cent of drug abusers or users were boys.

4.4.1 Reasons for being on the streets

Through their caregivers, children on the streets cited family reasons as the biggest push factor that removed them from home. Mistreatments by parents, guardians, or older siblings (beatings, torturous punishment, sexual abuse, food deprivation) were some of highlighted family reasons. Impoverished backgrounds also forced some other children to go out to the streets to fend for

themselves. Left without parents or guardians, children experienced the most difficulty accessing health care services by themselves and cannot stand up to any form of discrimination or report violations.

4.4.2 Occupations and incomes

The findings of this study indicate that the law which prohibits child labour has no place in the harsh street environment. Most children who are homeless are pre-occupied by sorting garbage for plastics and scrap metal for sale. This type of work pays very poorly as they compete with youths, adults and the elderly while exposing these children to a myriad of health hazards. It is, therefore, impossible for these children to take care of their health rights sufficiently. Many are likely to fall into drug dependency and lose initiative for their health needs.

4.5 Summary of Findings on PLAWS' health needs

4.5.1 Preferred treatment centres

Most of the respondents, that is 74 per cent, preferred to go to public health facilities whenever they felt sick. The reason given for such preference was the proximity to PLAWS areas of work or residence. While this indicates that public health facilities are accessible to PLAWS, it does not translate to provision of relevant and affordable services since most PLAWS reported knowledge of some form of discrimination to themselves and others, in addition to inability to afford the cost of treatment at health centres. Interventions to address PLAWS health concerns will achieve significant outcomes if implemented in public local health centres.

Thirty respondents, representing 19 per cent of PLAWS sampled, reported visiting health facilities run by NGOs whenever they are unwell. This preference is informed by their affordability and relevance. It was indicated that some of the health facilities run by NGOs offer diagnosis and treatment at no cost while others have specific health programmes for PLAWS. However, these NGO-run health facilities are not easily accessible to all PLAWS because they are few and far between communities. These organizations demonstrate a willingness to incorporate more targeted health programmes for PLAWS.

Eight per cent of the respondents sought treatment at either national referral hospital, county level 5 hospitals, pharmacies or herbalists and traditional healers. That no respondent visited private hospitals needs further investigation on whether they keep discriminatory policies against PLAWS or they are just prohibitively expensive.

Children on the streets cited family reasons as the biggest push factor that removed them from home.

4.5.2 Nature of discrimination/barriers met at health care facilities.

70 per cent of respondents had themselves either faced discrimination of some kind at health centres or were aware of discrimination faced by another within their community.
Commonly reported barriers and forms of discrimination point to three trends.

1. Monetary related barriers which are lack of money to pay services like hospital registration and laboratory tests, lack of money to buy drugs when referred to pharmacies and the like.
2. Discrimination of PLAWS based on their perceived inferior social status resulting in inability to produce valid documents (where) required for identification or continuation of treatment, inability to provide next of kin or sexual partners when asked to.
3. Poor perception of PLAWS by health service providers owing to their sometime intoxicated state and dirty appearance, which include long waiting time on queues (PLAWS reported being deliberately consigned to the end of the queue), being treated dismissively by hospital staff, being called names (thieves, drunkards, drug users), accident victims being mistaken for victims of mob injustice.

4.5.3 Awareness of health rights

The data points to a considerable level of awareness of health rights by PLAWS. Most of the mothers and adults were more aware of their health rights than children and youth.
Children may not have reached the age of proper awareness while the youth displayed a lack of agency and initiative on this issue.

Some commonly reported health rights known to PLAWS were:

- Right to be treated well and have continuity of care to full recovery.
- Right to seek and obtain information about healthcare.
- Right to privacy and dignified, respectful treatment at health centres.
- Right to ask and receive feedback concerning diagnosis and treatment protocols.

Awareness of health rights and when they are violated did not directly relate to awareness of reporting and redress mechanisms especially when the violation was because of structural barriers or discrimination. This could be attributed to:

1. A lack of initiative on the part of PLAWS to follow up, rising from the assumption following up is either costly or unhelpful. Youths and children PLAWS are particularly disadvantaged in this regard as they have no positive example to follow, are afraid and pessimistic of receiving any assistance.
2. There are no clearly defined reporting mechanisms known to PLAWS. They do not know where and who to report to.

The data points to a considerable level of awareness of health rights by PLAWS. Most of the mothers and adults were more aware of their health rights than children and youth. Children may not have reached the age of proper awareness while the youth displayed a lack of agency and initiative on this issue.

4.5.4 Common health challenges

Data from health service providers was used to identify health challenges faced by PLAWS per category. Some indicative health challenges raised by PLAWS and health care givers are highlighted below.

4.5.4.1 Children

Children living and working on the streets face various health challenges. The health care providers and children themselves concurred on the following key challenges:

- Malnutrition and poor growth rates associated with inadequate feeding.
- Respiratory illnesses from rough sleeping and exposure to hard weather.
- Stomach illnesses from consumption of food waste, poor hygiene.
- Skin diseases from poor hygiene.
- Psychological abuse due to exposure to street roughness and demands of independence from early age.
- Drug-abuse and related challenges.

4.5.4.2 Mothers

Mothers who participated in the study also face some unique health challenges. Some key ones are:

- Inability to follow up child clinic and immunization to completion.
- Malnutrition of lactating mother, manifesting in low milk production and retention in breasts (dry breasts), and poor body condition.
- Inadequate or lack of basic information on childcare, including pre, and post-natal care of mother and child.
- Drug-abuse and related challenges.
- Mental illness-depression, postpartum depression, and post-traumatic stress disorders
- Inadequate awareness of family planning.
- Limited access to reproductive health information, services and facilities, including strained use of contraceptives or lack of it

4.5.4.3 Youths

Youth face different health challenges too. Some of those identified during the study include:

- High risk of contracting and infecting HIV/STI- most youth are sexually active but do not use condoms, have limited knowledge of and access to PrEP or PEP.
- Drug abuse and addiction- youths are the most susceptible group for addiction having been introduced to drugs while young, which in part contributes to prevalence of reckless sexual behaviour.
- Sexual violence- female PLAWS are likely victims of forced prostitution or abuse by male PLAWS.
- High risk of physical injuries- male PLAWS in this category record incidences of work-related accidents, beatings, and other wounds.

4.5.4.4 Adults

Adults living and working on the streets also face varied challenges. Some of these are:

- Respiratory and chest related diseases
- HIV/AIDS and Sexual Transmitted Diseases
- Skin diseases
- Malaria and fever
- Poor work predisposes them to illness- long exposure to garbage sorting and collection as primary occupation predisposes them to frequent illness.
- Low life expectancy- poor work, inadequate sleeping, inadequate food, and inability to obtain complete treatment combine to significantly lower lifespan of PLAWS.
- Stress- psychological distress of being permanently homeless.

4.5.4.5 Drug users and addicts

Given that about 57.6 per cent of the respondents are substance users or abuser, some challenges emerge. These are:

- Shortage of rehabilitation centres, counselors, and advisers
- The criminality context of drug abuse/use reduces opportunities for confession and help
- Addicts ignore their health needs, focusing only on drug consumption.
- Inability to maintain clean status after rehabilitation, leading to relapse.
- Inability to keep a clean, responsible appearance heightens chances of discrimination at health facilities.

4.6 Findings on Health Service Providers

4.6.1 Health services specific to PLAWS

The study established that:

To the extent that PLAWS are members of the public, they are guaranteed access to healthcare services provided at public health facilities. Even as no particular services are tailored to PLAWS health concerns in these facilities, there is no policy of discrimination enforced against PLAWS. However, ease of access, affordability and relevance of health services is dependent on factors like perception of service providers, ability of PLAWS to clearly express their health needs, availability of Community health workers or volunteers to assist etc. Some sampled public health centres were: Kayole I Health Centre which provides care to all HIV positive youths as well as distribution of free condoms and PREP therapy to prevent spread of HIV. However, the level of use among men is far higher compared to females.

Westlands Health Centre has outreach services to inform and rehabilitate drug-users in the streets. The facility also offers medical services including to assault patients, rape cases and makes referrals for further treatment.

Ngara Health Centre Which provides comprehensive VCT and ART services to PLAWS infected with HIV/AIDS

There exist some health service providers specifically established with the aim of addressing some of the challenges PLAWS and other indigent groups face in attempt to gain access to healthcare

services. These providers are mostly non-governmental donors or church funded health centres. They include:
German Doctors-Baraka Mradi in Mathare offers best attainable health services to PLAWS and other disadvantaged persons at no charge.

They work with Community Health Volunteers (CHVs) to make follow-ups to evaluate effective case management while also offering public health information to instill urgency of their own (PLAWS) health rights and needs.

Total Health Advocacy Foundation (THAF) provides health services especially to the vulnerable groups, and to the public at large. Other than primary healthcare, THAF also offers free personal health advice to those who visit the hospital.

St Joseph the Worker Catholic Dispensary and Maternity Gichagi and St Teresa's Dispensary Eastleigh are faith-based health service providers offering quality health services to the local community who cannot pay for most private hospitals. Their specific programmes for PLAWS as a disadvantaged group include immunization campaigns, deworming, VCT and ART services.

4.6.2 Policies that inform PLAWS health interventions

Whereas there exist no specific mechanisms to operationalize the concept of vulnerable and marginal communities as captured in the Kenya Health Policy (2014-203), it remains the discretion of public health facilities to design how to treat PLAWS who visit their facilities, based on the generalities of existing health policies.

At Ngara Rhodes Avenue Dispensary, a respondent said that the TB-related interventions are in line with Kenya Latent Tuberculosis Infection Policy 2022 which guarantees free treatment to all citizens.

With reference to donor funded and faith-based health NGOs, data shows that dedication to charity work and commitment to the humanitarian value propositions was at the base of their interventions, which were subsequently guided by existing health policies.

4.6.3 Sustainability of interventions

Most respondents agree that the health interventions they have for PLAWS are neither sufficient nor sustainable.

The lack of a mechanism in the national health policy on how to address health challenges of the PLAWS, inability to collect and keep correct health records on PLAWS and insufficient funding for medical supplies to guarantee free medical care for PLAWS are among the reasons given. Further, few, if any clinical studies seem to have been done to identify health challenges that PLAWS largely face.

4.7 Key Informant Interviews

4.7.1 Indicators of health rights violations

Several instances and issues were picked out as manifestations of health rights violations faced and experienced by PLAWS, as here below enumerated:

a) Denial of access to health centres by hospital security, owing to disheveled appearance of PLAWS, often deliberately misconstrued as garbage collectors or trouble makers.
b) Denial of the medical services/ attention due to discriminatory perceptions and attitudes of healthcare workers, on the basis that PLAWS appear dirty, have bad odor and/or are intoxicated.

Physical assault of PLAWS by several segments of the community is rampant. For instance,

members of the public beat and chase them from their locales, while other physical maltreatment is perpetrated by chiefs and inspectorate officers of the Nairobi City Council commonly referred to as county askaris/ kanjos, as well as police officers on patrol. Besides they are exposed to forceful arrests, and beating which causes injuries and actual bodily harm.

c) Inadequate resources in public health facilities point to the fact that PLAWS will not be able to access some health rights such as affordable or free medication from public hospital pharmacies, especially with absence of a clear or targeted mechanism offering direct service.
d) Lack of representatives on relevant healthcare platforms (health matters) put PLAWS at a high risk of violation of their rights. Lack of representation creates gaps between CHWs and PLAWS, meaning they miss out on crucial health information and services.
e) Lack of access to emergency treatment- PLAWS that are victims of accidents or who fall severely ill in their places of residence cannot access ambulance services.
f) There are allegations that PLAWS are sometimes given medicine that has expired. It is alleged that this practice tends to occur when, their ability to pay for healthcare services is compromised, or inadequate.
g) Psychological abuse- constant ostracization, condemnation, victimization, persecution and mistreatment by several segments of society, owing the perceptions of PLAWS being social misfits, continuously drives them into feelings of despair, inferiority and mental stresses.
h) The impact of intolerance by people and institutions, has often resulted into an uncaring attitude amongst some of the PLAWS regarding their health status. In particular, instances of discrimination, the rough survival on streets and drug use contribute to loss of concern on health rights and needs.

4.7.2 Reporting mechanisms

There are no clearly defined reporting procedures available to PLAWS for whenever their health rights are violated. However, some working suggestions were raised such as;

a) Through demonstrations and picketing within a specific health facility to raise awareness of discrimination.
b) PLAWS may report to the relevant authorities within their communities such as chiefs, Nyumba Kumi representatives, local administration, and local political leadership.
c) They may also report to community health workers or volunteers, hospital administrators and social workers within the vicinity of the health centre.
d) The PLAWS may raise some of their grievances on health matters through mainstream media and at times through social media such as Facebook.

5.0 CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusions

This section highlights key conclusions as well as policy and legal implications drawn from the research. Further, it makes recommendations for better realization of health rights for PLAWS to enable them live a life of dignity.

This study may be the first of its kind in Kenya and fulfilled its objectives of establishing how health and healthcare experiences of PLAWS were formed on the dichotomy of responsiveness or repulsion, both in public and private health facilities. On the foregoing, there is evidence to demonstrate how difficult it is to realize PLAWS' health rights, given the socio-economic circumstances and the generalised design of the healthcare infrastructure in the country.

The fact that homeless individuals and communities present and represent higher incidence disease burden, are susceptible to contracting communicable diseases besides increased risk of premature death, in conspiracy with factors such as lack of health insurance, unattended to mental illness, depression, daily struggle to eke a living and addictions can limit PLAWS' ability to seek and access timely and appropriate health care services.

The research established that most of the PLAWS in Nairobi demonstrated health service hesitancy, and tended to avoid or fear seeking formal health care services, in part, due to their previous unpleasant encounters with healthcare providers. When, healthcare service must be sought, they prefer attending public health facilities or those run by charities and faith-based organisations. Rarely do they attend private health facilities as they feel discriminated against and ostracized.

In terms of migration, the counties of Nairobi, Kiambu, Murang'a, Machakos and Nyeri counties were the biggest contributors of persons living and working in the streets in Nairobi. This means that Nairobi County is a leader in both push and pull factors that force people to live and work on the streets. However, the push factors are evident in 17 other counties namely Kitui, Homa Bay, Kakamega, Kisumu, Nakuru, Meru, Vihiga, Siaya, Kisii, Makueni, Embu, Mombasa, Nyamira, Kericho, Busia, West Pokot and Uasin Gishu in varying degrees. The question that should concern health experts, is what dangers do such migratory patterns present, especially in the context of communicable diseases? Could there be any risk factors associated with certain illnesses that may jeopardize the bigger population of Nairobi?

Six in 10 of persons live on the streets because of family related reasons. However, the reasons for being on the streets vary by gender, with most males doing so as a result of orphanhood, disagreement or mistreatment by siblings/relatives /parents, fear of being reprimanded, fear of corporal punishment, and lack of school fees. Females are mostly on the streets due to domestic violence, forced evictions, poverty and or due to personal survival choices.

Majority of the PLAWS seek health services from public hospitals and charity owned health facilities especially for fever, malaria or physical injuries. They, however, prefer self-medication where the health challenges are respiratory, reproductive including sexually transmitted diseases. Self-medication is largely as a result of fear of being diagnosed with some diseases that are publicly stigmatizing like Gonorrhea, syphilis or those largely believed to be terminal-diseases like HIV/AIDS, cancer, and Tuberculosis.

Drug addiction and abuse is quite prevalent among PLAWS. This is because 8 in every 10 persons living on the streets were either using drugs in the last six months preceding the study. It is our considered view that this problem of drug addiction and abuse leads to more cases of mental illness and /or is an escape route from other forms mental illness. While a critical number of those who used drugs before were keen to change either voluntarily or on receiving medical advice from health service providers, there is no clear policy nor dedicated government health care facility to assist in rehabilitation.

While this study never discovered findings from any previous clinical research, a number of PLAWS indicated to suffer depression, anxiety disorders, post-traumatic stress disorder (especially those evicted from homes or who witnessed parental violence) and other forms of mental illness. None of the health care facilities nor health care givers seemed to have any programme or even ad hoc interventions to deal with the issue of mental illness. The only government mental health facility- Mathare only admits on referral and was largely inaccessible to all the PLAWS interviewed in the study.

Several PLAWS interviewed pointed out that they do not use any contraceptives and have suffered HIV and Sexually Transmitted Infections (STIs). Given the early onset of sexual activities of children and the youth living on the streets, a continued lack of clear policy and programmes may lead to bigger health challenges for the homeless.

5.2 Policy and Programmatic Recommendations

The research makes the following policy and programmatic recommendations.

5.2.1 Holistic Street Families Policy

There is a dire need for the development and implementation of strategic mechanism to operationalize a holistic street families' program since the Kenya Health Policy 2014-2030 provides for the indigent, marginalized and most vulnerable. Such a mechanism will among other areas speak to the fulfilment of the economic and social rights of persons living and working on the streets as provided for in Article 43 of the Constitution of Kenya, 2010. These economic and social rights include development programmes that propagate street families to the highest attainable standard of health, which includes health care services reproductive health care and mental health care.

A subset of the strategic mechanism must clearly speak to the issue of health financing for street families, as part of the Social Protection policy that has reiterated the place of National Hospital Insurance Fund (NHIF), to be part of Universal Healthcare Coverage. The national government and county governments must fully identify the specific health needs of PLAWS and allocate funds to local health centres so that they provide free comprehensive health care services to PLAWS. This part of the policy would reduce or eliminate financial disparities and demands among the PLAWS, leaving them to contend with only visiting a health facility of their choice.

The Social Protection Policy is required to particularly enshrine interventions for institutional and community reintegration of street families, including the sensitization of healthcare workers on the plight of PLAWS. This would eliminate negative attitudes towards PLAWS and establish a welcoming environment in health centres.

The healthcare policy should dedicate a program and strategy on how PLAWS may access certain critical medicines for free in select public and charity health care facilities. This will likely lessen the out-of-pocket expenses that make health care too expensive for the indigent to afford.
Given that health care services are largely devolved, all counties, especially those that are currently the home to many homeless people, need to designate, equip and support at least one hospital in each sub-county to offer dedicated health care services to this category of their population.

5.2.2 Development and Implementation of Preventive Support Programmes

Family issues which include domestic violence, poverty or being born on the streets are the biggest push factors contributing to the surging numbers on the streets. We recommend that the Street Families Trust Fund in collaboration with Undugu Society of Kenya develops and implements family support programmes to vulnerable street families that would allow their reintegration into society. Further, other social programmes implemented by the national and county government need strengthening to reduce the state of impoverishment, that tend to relegate destitute families letting their members into the streets. It is further recommended that the homeless be facilitated to attain birth certificates and national identity cards as may be appropriate. These documents are necessary for anyone who wants to access services and benefit from social programmes. That most of them lack is equivalent to denying them dignity.

5.2.3 Rehabilitation and Mental Health Support Programmes

Mental health stood as a major challenge, owing high drug dependence amongst the PLAWS. It is recommended that the national government in collaboration with select county governments sets up targeted rehabilitation and mental health support programmes for persons living and working on the streets. This will go a long way in fulfilling the state's obligations under the constitution of Kenya but also assisting in fighting stigmatization and reducing certain types of crimes largely committed by PLAWS. This is an area where Undugu Society of Kenya' strength can be utilised, as it has decades of knowledge and experience on how to run sustainable rehabilitation programmes. Undugu Society of Kenya could also get more interested in the mental health support programmes

and support select counties in development and implementation of effective and sustainable mental health policies and support programmes.

5.2.4 Vaccination Programmes

While the study finds that most of the children considered or who consider the streets as their first home, were vaccinated at either Pumwani or Mbagathi hospitals, the youth, mothers and adults interviewed missed out on other essential vaccination programmes. For instance, most (80 per cent of the respondents) had not received even a single Covid-19 vaccine. This is because they lacked identity card numbers or reliable individual mobile phone numbers which seemed to have been critical identifiers for one to receive Covid-19 vaccines. It is therefore recommended that non-discriminative tailor-made protocols and projects are designed to reach PLAWS whenever there is a national vaccination programme.

5.2.5 Access to and use of health and healthcare information

Decisions are often made based on the quality and timeliness of the information received or held by decision makers. Article 35 of the Constitution provides the basis upon which information must not be denied to anyone. Owing the prevalence of misinformation, and misrepresentation of facts as established by the study amongst this group, it is necessary that information is translated and transcribed data sets that can be understood and utilised by PLAWS. Similarly, the need to design responsive and accessible information sharing platforms, that may include the use of social media, local safety spaces and street bases to reach them.

5.2.6 Health care education across board

The importance of healthcare education has been seen to increase uptake and utilization of health and healthcare services. The healthcare service providers need to understand the place of equity as a strategy to locate inclusion in their services (mandate), while PLAWS need it for necessary and timely decision making, besides uptake of services. On the part of security firms that man healthcare facilities, to develop the right attitude towards PLAWS, and become the entry or engagement point into healthcare facilities, rather than the premature disengagement agents they seem to be.

5.2.7 Human Resource Support system

Health and healthcare experiences amongst the PLAWS largely speaks to the importance of encounters with healthcare service providers. Their encounters inform and form their opinion regarding access to facilities. It was noted that healthcare service hesitancy is common, for various reasons, but majorly for the fear of discrimination and stigma. In inducing initiative to access and increase uptake of services, including nationally run vaccination programmes, there is need for the healthcare service personnel to be trained in people-oriented service provision and vulnerable sensitive culture, to advance opportunities for inclusion. Such a support system can be integrated within a functional Community Health Worker scheme, as a measure to reduce misinformation, but more importantly to create safe spaces for the PLAWS to participate and access healthcare service.

Annex 1: List of Research Assistants

1. Ms Linet Olando
2. Mr Benjamin Maina Okama
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6. Ms Grace Moraa
7. Mr Aloys Oketch
8. Mr John Githimba
9. Ms Jacinter Njeri
10. Ms Mary Wanjiku
11. Mr Samson Sila
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13. Mr Reagan Opiyo
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MASENO UNIVERSITY SCIENTIFIC AND ETHICS REVIEW COMMITTEE

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REF: MSU/DRPI/MUSERC/01223/23 **Date**: 15th May, 2023

TO: Henry Omusundi Maina
Undugu Society of Kenya
Arnold Plaza 5th Floor
Woodvale Grove Road, Westlands
P.O. Box 40417-00100, Nairobi, Kenya

Dear Sir,

RE: Receptiveness or Repulsiveness of Encounters of PLAWS with Healthcare Providers

This is to inform you that **Maseno University Scientific and Ethics Review Committee (MUSERC)** has reviewed and approved your above research proposal. Your application approval number is MUSERC/01223/23.The approval period is 15th May, 2023 – 14th May, 2024.

This approval is subject to compliance with the following requirements;

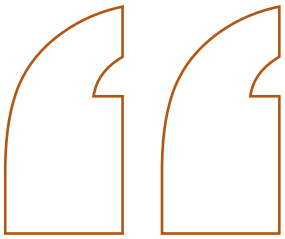
i. Only approved documents including (informed consents, study instruments, MTA) will be used.
ii. All changes including (amendments, deviations, and violations) are submitted for review and approval by Maseno University Scientific and Ethics Review Committee (MUSERC).
iii. Death and life threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to Maseno University Scientific and Ethics Review Committee (MUSERC) within 24 hours of notification.
iv. Any changes, anticipated or otherwise that may increase the risks or affected safety or welfare of study participants and others or affect the integrity of the research must be reported to Maseno University Scientific and Ethics Review Committee (MUSERC) within 24 hours.
v. Clearance for export of biological specimens must be obtained from relevant institutions.
vi. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. Attach a comprehensive progress report to support the renewal.
vii. Submission of an executive summary report within 90 days upon completion of the study to Maseno University Scientific and Ethics Review Committee (MUSERC).

Prior to commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology and Innovation (NACOSTI) https://oris.nacosti.go.ke and also obtain other clearances needed.

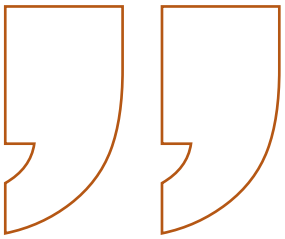
Yours sincerely

Prof. Philip O. Owuor, PhD, FAAS, FKNAS
Chairman, MUSERC

MASENO UNIVERSITY ETHICS REVIEW COMMITTEE 15 MAY 2023



The healthcare service providers need to understand the place of equity as a strategy to locate inclusion in their services (mandate), while PLAWS need it for necessary and timely decision making, besides uptake of services. On the part of security firms that man healthcare facilities, to develop the right attitude towards PLAWS.



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