The Future Of Human Rights In The Digital Age:

Youth Perspectives on digital Empowerment, Inclusion, and Governance in Kenya

KELIN
Reclaiming Rights, Rebuilding Lives

KCAT
KENYA COMMUNITY ADVISORY TEAM

DHRP
Digital Health & Rights Project

Project Funding

This project was funded through a grant from Foundation Botnar. The funder played no role in the design, data collection and analysis.

Project Scope

The study was conducted in four counties in Kenya: Nairobi, Mombasa, Kitui, and Migori. Participants were purposively sampled and included young people aged 18–30 years, with a focus on those living with HIV, men who have sex with men (MSM), and female sex workers (FSWs)

Citation

KELIN (2025). The Future of Human Rights in the Digital Age: Youth Perspectives on Digital Empowerment, Inclusion, and Governance in Kenya. Research Report.

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1.0 Executive Summary

Kenya's digital landscape, characterized by a 92% internet penetration rate and a youthful population (over 60% under 25), is at the forefront of Sub-Saharan Africa's technological revolution. This transformation offers significant opportunities for enhancing access to health information and services, particularly for young people. However, persistent inequalities—gender disparities, rural-urban divides, and socioeconomic barriers—exacerbate the digital divide, disproportionately affecting marginalized groups such as people living with HIV (PLHIV), sex workers, and LGBTQ+ individuals. This study, part of a 4-country study, conducted by the Digital Health and Rights Project (DHRP) in Colombia, Ghana, Kenya and Vietnam was led in Kenya by the Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN) and Warwick University. It examines how young people living with HIV (PLHIV), young female sex workers, and young LGBTQ+ individuals navigate digital spaces, focusing on empowerment, inclusion, and governance from a human rights perspective.

Employing a participatory action research (PAR) approach, the study engaged 109 participants aged 18–30 across Nairobi, Mombasa, Kitui, and Migori counties, selected for their diverse geographic and demographic profiles, internet penetration and key population organizations. Data was collected through focus group discussions (FGDs), semi-structured key informant interviews (KIIs), and legal/policy

Kenya's digital landscape offers significant opportunities for enhancing access to health information and services, particularly for young people.

This study examines how young people living with HIV (PLHIV), young female sex workers, and young LGBTQ+ individuals navigate digital spaces, focusing on empowerment, inclusion, and governance from a human rights perspective.

analysis, ensuring meaningful involvement of youth, including key populations. Ethical considerations prioritized participant anonymity, informed consent, and protection from stigma and harm.

Findings highlight three primary barriers to digital inclusion: stigma, economic constraints, and educational/cultural limitations. Stigma, reported by 67 participants, drives self-censorship and fear of exposure, particularly for PLHIV and LGBTQ+ youth. Economic barriers, noted by 64 participants, include unaffordable devices and data, limiting access to platforms providing health information. Educational and cultural constraints, such as low digital literacy and societal taboos, further hinder engagement. Additionally, surveillance (by family, peers, and government), technology-facilitated abuse (e.g., cyberbullying, blackmail), and poor data protection erode trust in digital health systems. Community-led responses, including peer-led WhatsApp groups and advocacy campaigns, demonstrate resilience but are constrained by privacy risks and resource limitations.

The study recommends strengthening and enforcement of data protection laws, youth-focused digital literacy programs in local languages, privacy-by-design features in health apps, and donor-funded youth-led innovations. By integrating rights-based governance and drawing on the HIV movement's community-led approaches, Kenya can build an inclusive digital ecosystem that empowers youth, advances health equity, and safeguards human rights in the digital age.

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Glossary

Algorithmic Bias: Refers to systematic and repeatable errors in a computer system that create unfair outcomes, such as privileging one group over others; the risk of AI-driven healthcare tools reinforcing inequalities due to biases and gaps built into data and models.

Data Colonialism: The exploitation of personal data by powerful entities, often without consent, mirroring colonial practices by extracting value from marginalized populations, particularly in digital health contexts.

Digital Divide: Unequal access to and ability to use digital technologies.

Digital Health Literacy: The ability to find, understand, use, and share digital health information for health decisions.

Digital Literacy: The ability to access, evaluate, and use digital tools and content effectively and safely.

Key Populations (KPs): In the HIV response, key populations include gay men and other men who have sex with men, sex workers, people in prisons and other closed settings, people who inject drugs, and transgender and gender-diverse people.

Participatory Action Research (PAR): A research approach that involves community members in designing, implementing, and analysing the study, ensuring their perspectives shape the outcomes.

Stigma: Stigma is a difference that is distinguished and labelled, which then enables a range of discriminatory actions that ultimately deny people full social acceptance, reducing their life chances and fuelling social inequalities.

Surveillance: Monitoring of individuals' digital activities by family, peers, private companies, or government entities, often compromising privacy and safety in health-related contexts.

Technology-Facilitated Abuse (TFA): Abuse that is committed, assisted, aggravated or amplified using internet and communication technologies or other digital technologies, that results in or is likely to result in physical, sexual, psychological, social, political or economic harm, or other infringements of rights and freedoms.

List of Abbreviations

AI	:	Artificial Intelligence
AIDS	:	Acquired immunodeficiency syndrome
DHRP	:	Digital Health and Rights Project
FGD	:	Focus Group Discussion
FSW	:	Female Sex Workers
GSMA	:	Global System for Mobile Communications Association
HIV	:	Human Immunodeficiency Virus
ICT	:	Information and Communication Technology
IDIs	:	In-depth Interviews
KCAT	:	Kenya Community Advisory Team
KP	:	Key Populations
LGBTQ+	:	Lesbian, Gay, Bisexual, Transgender, Queer, and others
LMICs	:	Low- and Middle-Income Countries
MSM	:	Men who have Sex with Men
NGOs	:	Non-governmental Organisations
OHCHR	:	Office of the High Commissioner for Human Rights
PEP	:	Post-Exposure Prophylaxis
PrEP	:	Pre-Exposure Prophylaxis
SMS	:	Short Message Service
SRHR	:	Sexual and Reproductive Health and Rights
TB	:	Tuberculosis
TFA	:	Technology-Facilitated Abuse
UK	:	United Kingdom
UN	:	United Nations

1.0 Introduction

Kenya stands at the forefront of the digital revolution in Sub-Saharan Africa, driven by rapid technological innovation and high internet penetration, estimated at 92% (We Are Social & Meltwater, 2023). Factors such as affordable smartphones, improved infrastructure, and government strategies like the National Broadband Strategy have accelerated digital adoption. With over 60% of the population under 25, the country is poised for a tech-driven transformation. However, while young people increasingly access health services and information online, they are rarely involved in shaping the policies governing their data collection and use (Wong et al., 2021; Cath, 2021). Kenya's digital revolution presents critical opportunities and challenges in ensuring the accessibility, availability, and quality of health for all.

Inequities in Access: Despite high internet penetration (92%) and mobile device use accounting for 72% of web traffic (Natalie, 2023), digital divides persist, especially for women, rural populations, persons with disabilities, and low-income groups. Language remains a barrier, particularly for those less fluent in English (Davis, Pham, Kpodo et al., 2023). While mobile ownership is widespread, access to smartphone-based apps remains limited, excluding millions who cannot afford them (Gebayew et al., 2018; GSMA, 2020). Infrastructure gaps further exacerbate these inequalities across Kenya's dispersed geography.

Human Rights Risks: Although digital health tools and AI offer potential to transform health systems, they also raise serious human rights concerns. These include risks to privacy, autonomy, equality, and sovereignty (Martens, 2018; Anand, 2022; Özdan, 2023), as well as algorithmic bias, data colonialism, and weak data protection that can lead to surveillance and targeting (UN Human Rights Office, 2020; Zuboff, 2019; Couldry & Mejias, 2019).

Impacts on People Living with HIV and Key Populations: Kenya continues efforts to combat HIV, with 1.4 million people living with HIV in 2024 (National Syndemic disease Control Council, 2024). Key populations, including sex workers and MSM, face disproportionately high prevalence (18.2%) (Mwaniki et al., 2023). Digital platforms offer crucial access to health information and services for stigmatized and criminalized groups, enhancing reach and reducing barriers (Dasgupta, 2015). Yet, digital harms—such as online violence, surveillance, and misinformation—pose new threats. Many prefer to remain "uncounted" in health studies due to fears of exposure and criminalization (Davis et al., 2020). Resistance to mapping hot spots or biometric data collection reflects concerns over privacy and safety (NSWP, 2015; KELIN, 2017).

Governance Gaps: Kenya has made strides in digital health governance, through frameworks such as the National eHealth Strategy (2011–2017), the National eHealth Policy (2016–2030), the Digital Health Act (2023) and the Data Protection Act (2019). However, meaningful participation, especially by marginalized groups, is still lacking in the design and implementation.

Placing Rights at the Center: In 2022, UN leaders reaffirmed that human rights must be central to tech governance (OHCHR, 2022). The HIV movement offers valuable lessons in asserting privacy, non-discrimination, and accountability through community-led approaches. This study, The Future of Human Rights in the Digital Age: Youth Perspectives on Digital Empowerment, Inclusion, and Governance in Kenya, draws on the HIV response to explore how rights-based governance can be embedded in digital transformation.

The Digital Health and Rights Project, established in 2019, is a global consortium of researchers, activists, and organizations advocating for human rights in digital health. It includes partners from Kenya, Colombia, Vietnam, Ghana, the UK, and beyond. Through participatory research with youth in LMICs, the project examines how digital tools intersect with structural inequalities such as gender, criminalization, and economic disparity. While youth find digital platforms empowering, many face risks like surveillance, technology-facilitated abuse, and misinformation. The project calls for intersectional, feminist, and decolonial approaches to digital governance, and seeks to empower youth as active participants in shaping digital futures.

2.0 Methodology

The study was guided by the following research questions

i. What is the future of human rights in the digital world, and what role can diverse grassroots communities in LMIC play in shaping that future?
ii. How do young adults experience multiple digital divides (e.g. gender, race, sexual orientation, nationality, language, socio-economic class, and geography, among other factors) as intersecting to shape their empowerment or disempowerment?
iii. How do populations who are criminalised and stigmatised (including LGBTQ+ people, sex workers, migrants) experience the risks and realities of state surveillance in the digital transformation?
iv. What kinds of digital literacy and empowerment do young adults and communities need and want?
v. What lessons can be learned from the HIV movement as a case study to inform future thinking, mobilisation and advocacy that promotes human rights in digital technologies?

2.1 Study design and Sampling strategy

The study employed a qualitative and participatory action research (PAR) approach, incorporating field interviews and legal and policy analysis. PAR enabled meaningful involvement of the target group – young people and key populations – in shaping the research process, including design, implementation, and analysis (Baum, 2006; Kindon, Pain & Kesby, 2007). To this effect the study established Community Advisory Teams (CAT) made up of former study participants and civil society representatives, including digital human rights and health rights groups. The CAT identified focus areas and populations in each country from a shared list; provided advice on research methods; reviewed and contextualised all research instruments; and led recruitment and mobilisation of study participants with some participating as research assistants. The study was conducted in four counties: Nairobi, Mombasa, Kitui, and Migori. These counties were selected for their diverse geographic representation, high youth populations, strong digital connectivity, and presence of organized key populations. Participants were purposively selected and included young people (18–30 years), including those living with HIV, men who have sex with men, and female sex workers, who were either using or aware of mobile health (mHealth) technologies related to HIV, TB, and SRHR.

2.2. Data collection methods

The study utilized a qualitative method approach, combining participatory action research (PAR), legal and policy analysis, and techniques from sociology and anthropology. The data collection involved several key methods:

i. **Law and Policy Review:** The study began by updating Kenya's legal and policy landscape, establishing a foundational reference for the research. This process included input from local and international researchers.
ii. **Semi-structured Key Informant Interviews:** 6 interviews were conducted with experts in digital health governance, including health practitioners, digital health rights advocates, and community leaders, providing in-depth insights into the subject matter.
iii. **Focus Group Discussions (FGDs):** 16 FGDs were conducted (4 in each county) to explore the experiences and perspectives of young people on digital health technologies and access to healthcare services and information. In addition, their perspectives on the future they envision for their online spaces was explored. Data was anonymized during analysis, ensuring confidentiality.

2.3 Ethical considerations

This study received ethical approval from the AMREF Ethics and Scientific Review Committee (Approval No. ESRC P1582/2023) and a national research license (NACOSTI/P/24/34618) from the National Commission for Science, Technology and Innovation (NACOSTI) before fieldwork commenced.

During in-person interviews, such as key informant interviews and focus group discussions, signed informed consent from participants was sought. The informed consent process included a clear verbal explanation of the study, clarification of participants' roles, and obtaining informed, voluntary consent, ensuring participants fully understood their rights, including the freedom to withdraw at any time without consequence. This study recognized the potential risks faced by people living with HIV and key populations, including stigma, discrimination, and safety concerns, and took comprehensive measures to protect participants' identities and well-being. Strategies employed include anonymizing data, obtaining informed consent using clear language, regular risk assessments, and ensuring voluntary participation without disclosing sensitive information. Efforts were also made to minimize participant burden and provide compensation for time and expenses.

2.4 Participant Distribution by county and self-reported gender

The study involved 109 participants across four counties—Kitui, Migori, Mombasa, and Nairobi—capturing a broad range of self-reported gender identities. Overall, the participant pool comprised 53 males, 47 females, 5 transgender individuals, and 4 non-binary individuals. Kitui had 27 participants, with a near-equal split between 13 males and 14 females, and no gender-diverse participants. Nairobi County had the highest number of participants (30), with 14 self-identifying as male and 16 as female. Migori presented a similar binary structure with 14 males and 13 females but had one participant self-identifying as non-binary. Mombasa stood out with a uniquely diverse sample of its 24 participants, 12 participants self-identified as male, 4 as female, 5 as transgender, and 3 as non-binary.

Table 1: Participant Distribution by county and self-reported gender

County	Male	Female	Trans	Non-binary	Total
Kitui	13	14			**27**
Migori	14	13		1	**28**
Mombasa	12	4	5	3	**24**
Nairobi	14	16			**30**
Total	**53**	**47**	**5**	**4**	**109**

3.0 Findings

This section presents the study findings grouped by key emerging themes: Barriers to digital inclusion, digital safety and privacy and digital awareness and empowerment.

3.1 Barriers to Digital Inclusion

Barriers to digital inclusion are the obstacles that prevent individuals and communities from fully accessing, using, and benefiting from digital technologies and online resources. In this research, digital inclusion plays a vital role in enhancing the access to health information and services including access to sexual and reproductive health and rights (SRHR) information and services for young people. However, access to these resources is not evenly distributed resulting into digital exclusion.

Our findings identify three primary categories of barriers that hinder young people's involvement in accessing health information on digital platforms including stigma, economic hardship, and educational/cultural constraints. These barriers often intersect with each other and other aspects, creating divides that marginalize already vulnerable groups such as young LGBTQ+ persons, youth living with HIV, and those in rural or economically disadvantaged areas.

While digital platforms offer considerable potential to enhance access to health including SRHR information, these opportunities are undermined by issues such as discrimination, data and device affordability issues, and conservative socio-cultural norms. The following subsections present a deeper analysis of these barriers, grounded in qualitative evidence and direct quotes from study participants across Kitui, Migori, Mombasa, and Nairobi counties.

3.1.1 Stigma

Stigma remains a significant barrier to achieving digital inclusion, particularly in the context of sexual and reproductive health and rights (SRHR). It manifests as the fear of judgment, discrimination and potential exposure, often stemming from entrenched societal norms and perceived digital surveillance. Young people navigating SRHR issues are discouraged from seeking or sharing health information online due to stigma. This is further worsened by concerns about digital privacy, shared device use, and the risk of online harassment, particularly for vulnerable groups such as young women, LGBTQ+ people, and individuals living with HIV.
Across the four study counties, stigma turned out to be one of the major barriers to access to

health information on digital platforms as noted by 67 participants. The most incidences of stigma were reported by female participants, followed by male participants. Participants reported that they had withdrawn from digital platforms due to abuse, violations of privacy, and fear of being judged based on their health status, sexual interests and/or identities.

County Findings

In Kitui, stigma results from social isolation triggered by exposure of health information or sexual orientation on digital platforms, especially among key populations such as sex workers and MSM. Participants described using pseudonyms and multiple SIM cards to mask their identity.

A 28-year-old female participant living with HIV shared:

> **"Fine, thank you. I think it affects you, for example, I had not disclosed my status, nobody knows if I'm HIV positive or using these drugs. An example my friend gets my phone and accesses our groups, they get that information. And like she had said, some take screenshots. And sometimes they might start telling you, or people start isolating you, when they isolate you, you become stigmatized. You will start asking yourself what happened, and at long last when you come to know that they already know your status, you will start being in denial, and at long last you find some people committing suicide, and we don't know the information behind it"**
>
> Female participant, Kitui (2024-KTU-FGD9-64)

In Migori, participants were more afraid of being outed online or blackmailed for their sexual orientation, leading to self-censorship.

> **"I don't always share my sexual orientations online because maybe someone there might know me and, with the information I'm sharing there, it can be easy for him or her to blackmail me. So, I don't always share."**
>
> 23-year-old male participant, Migori (2024-MIG-FGD7-49)

Non-binary and trans participants in Mombasa described online spaces as hostile. The fear of cyberbullying and moral policing led many to avoid engaging online, even when sharing accurate SRHR information.

> **"I'm speaking about cyberbullying. So, cyberbullying comes hand in hand because most people, like us, love expressing ourselves online, So, you find someone who comes and tells you, don't talk about this, don't discuss this topic. Let's say you're talking about PrEP, let's say you're talking about STIs maybe you're talking about condoms, and they are like don't talk about these topics, it's not right. So, you find that the more you want to give information out there, there are people who will lower your self-esteem and also, depression comes hand in hand with that. So, you can't go and educate other people just because of cyberbullying and the words which they are using. The words they use are foul, So, you find that you don't have that courage to share. So, you find that even if you're saying something right, they will use that against you, that's why most people like us, we don't like going online and talking about these things"**
>
> 24-year-old non-binary participant, Mombasa (2024-MSA-FGD14-92)

Female participants in Nairobi reported high levels of stigma that often stemmed from fear of privacy breaches and reputational damage, especially among young women and sex workers. Shared or unattended devices were flagged as major risks. A 28-year-old female participant had this to say:

> **“Yeah, some people have better. Us as sex workers we face a lot of challenges. Sometimes you get your photos being leaked out there and some videos you get into mental illness. You get stigma from society. Because you see these days everyone has a smartphone. You don’t know who will see? You don’t even know if your father has seen”**
>
> Female participant, Nairobi (2024-NBO-IDI-2)

3.1.2 Economic

Economic barriers to digital services encompass a range of financial constraints that prevent individuals, especially young people, from accessing and utilizing digital technologies and platforms. In the context of sexual and reproductive health and rights (SRHR), these barriers disproportionately affect vulnerable youth, especially those who rely on digital platforms for safety, health information, and community connection. Nationally, economic barriers were reported by 64 participants across the four counties, with higher proportions among females at 34, males at 26, and all the 4 non-binary youth participants. Key populations, such as sex workers and LGBTQ+ youth, were disproportionately affected due to their increased dependence on digital platforms for livelihood, safety, and community support. They also faced higher costs for apps and data, risks of surveillance, and difficulties with device-sharing. Participants described a range of economic challenges, including the inability to afford smartphones, limited funds to buy data and or internet access, dependence on others like parents or partners for devices or airtime and in other cases, resorting to borrowing just to stay connected. These conditions not only restrict digital participation but also limit young people’s autonomy, confidentiality, and access to vital health resources.

A 29-year-old gay male participant in Nairobi explained:

> **“…So, I am also paying queer taxes on this app. Because even when we are meeting, we have to look at the location where we are meeting, I will not meet you at [place] because it is my place, and I am not sure if it will be safe. So, I will still use the same internet to send you a location to meet in town. I am also using a lot of resources to meet you. So economically we are prompt to pay more money to meet a fellow person. It is not like a straight person who will meet a girl and they like each other and go with her to his place. So, I have to use money to some extent to meet this person in the house. Maybe at CBD or in a hotel where we can meet because that is the safest place. I will buy you lunch, we will talk, and everyone will leave. So, I find that when we are prompted to use the internet more than any other community. We are prompt to pay a lot of money for these applications because it is also impossible to engage with communities. After all, we cannot access every person who is queer around us because we are scarce”**
>
> Female participant, Nairobi (2024-NBO-IDI-2)

County Findings

Sex workers in Kitui highlighted the danger of not being able to afford bundles to communicate with colleagues when in unsafe situations. Without reliable access to data, their safety and livelihood were compromised.

A 28-year-old female shared:

> **"Take an example where you don't have bundles and you are in a lodging somewhere. You don't trust this client and you know very well he will not give you time to update your friend. If you had data bundles you could have texted your friend and told them that you don't trust the client you are with right now, so don't go far. …… People are being killed there because they were not able to tell their friend about the clients they were with"**
>
> FSW participant, Kitui (2024-KTU-FGD9-64)

In Migori, the youth reported frequent reliance on shared devices, of parents or partners, due to lack of funds to acquire personal smartphones. This raised fears around privacy and restricted access to confidential health information.

A 20-year-old male participant explained:

> **"Let me say that. Maybe you don't have a smartphone, but you're using your parents' smartphone. So, you find that it becomes so difficult when you want to use this smartphone to access whatever you want. Because you are sharing with your parent."**
>
> Male participant, Migori (2024-MIG-FGD7-45)

Another 28-year-old female participant added:

> **"I share my phone with my husband so sometimes he checks the messages on Facebook, and WhatsApp, and with who I chat with. He even knows the password. So, this has made me to be very careful otherwise he will find everything there...(laughter)"**
>
> Female participant, Migori (2024-MIG-FGD8-57)

Amongst the youth in Mombasa, device and data inaccessibility were compounded by reliance on shared laptops or phones, which compromised privacy. A 24-year-old non-binary youth stated:

> **"So, you find when someone borrows my phone, most of the time I wonder what do you want to do? So, now you find I'm scared to share it, because sometimes maybe you are high, and you find there is that fear that someone using your phone may find out. These days these smartphones don't have any secrets, because you can even put information somewhere and it ends up reaching another person, I even hear that some people can search your name on google to look up your information and other stuff. Like they can find your history and other things so, a lot of people are fearful of that. So, I think that supports the other point."**
>
> Non binary youth, Mombasa (2024-MSA-FGD14-92)

In Nairobi, youth reported high data costs and app subscription fees as hindrances to essential digital health services access. This results in many resorting to risky alternatives like home deliveries due to inability to afford urgent care or mobile airtime.

A 28-year-old female participant noted:

> **"And also, when you don't have that access you literally using your own way. And most of. For example, there are people who literally die by giving birth at home. And it's something that they … maybe would have just called an ambulance to pick them up. Or maybe they opt to go for herbal treatments because they are ashamed."**
>
> Female participant, Nairobi (2024-NBO-FGD1-4)

3.1.3 Education/Cultural

Educational and cultural barriers greatly impede young people's ability to access sexual and reproductive health and related information from digital platforms. These barriers are influenced by a mix of inadequate formal education, limited digital literacy, and entrenched cultural and religious beliefs that discourage open discussion about digital tools and online health information.

Nationally, barriers related to education are significantly shaped by stigma, misinformation, and cultural norms. Participants highlighted how fear, stigma, and lack of exposure to digital technologies prevent many from seeking online SRHR content. Additionally, cultural taboos and perceived gender roles create environments where discussing health issues, particularly those related to sexuality or identity, is discouraged. This isolates further those already marginalized. These challenges reinforce the digital divide, restricting access to important information and support services for those who require them most.

County Findings

In Kitui, participants reported low digital literacy and a lack of trust in online spaces and a preference for local interactions over digital engagement. This was fuelled by fears of account hacking, gossip, and platform surveillance.

A 29-year-old female participant explained:

> **"Because sometimes like Facebook. Someone can hack your account and start posting things using your account and even start texting people to send them money. So we feel our information is not that secure online......Information is not secure on the phone and the government should teach us on issues surrounding IT. If someone wants to access your information, you can change the password fast before they get your information. So, we should be more informed about IT."**
>
> Female participant, Kitui (2024-KTU-FGD9-59).

Educational and cultural stigma led participants in Migori to self-censor or avoid online engagement altogether, even when they had important insights to share. One participant explained:

> **"For example, you might have a point that you want to discuss with other people, but you fear talking to this people online and feel like if I say my point, they will have a certain perception about me. Or even I post it on social media, maybe 2024-MIG-FGD5-36 knows me as 2024-MIG-FGD5-34, I may be exposed."**
>
> Female participant, Migori (2024-MIG-FGD5-35)

Cultural stigma and online hostility hindered active participation among young people in Mombasa, especially those from marginalized communities. One woman reflected:

> **"I agree with what has been said because there's something called KOT (Kenyans on Twitter). Those people are ruthless. Those people can shred you like a shredded chicken. What I usually do is filter my audience. I don't know for me, because I have blocked so many people from Facebook that I feel like someday Facebook will tell me that you love blocking (laugh). Because I'm a person who loves positive vibes."**
>
> Female participant, Mombsasa (2024-MSA-FGD13-91)

Similarly, another 28-year-old male participant in Nairobi explained how gender norms around masculinity reinforce secrecy and hinder open health-seeking behaviour among men:

> **“It is true. According to what you have asked, men are affected the most in this perspective, men are very secretive, and men are people who might be hungry but because of pride, they will tell no one he is hungry. You find that if he has health issues, he will struggle alone to solve them. That is why most of the time we go to Google so that even if I am treating myself no one should know what I am treating that information is safe with Google since it does not know me. I will just go to the chemist and pick up the drugs. Even wherever he stays at home no one will know where he will hide the drug. (laughter) So it affects men more than women because women are very open even at the salon but for a man, if he notices that his secret is about to come out in a gathering, he will leave that place. So, it affects men the most.”**
>
> Male participant, Nairobi (2024-NBO-FGD3-18)

Implications

The findings highlight how barriers related to stigma, economic hardship, and educational or cultural limitations significantly impede the ability of young adults in Kenya to access and benefit from digital platforms, especially in the context of sexual and reproductive health and rights (SRHR). These barriers intersect and amplify existing inequalities, particularly for women, persons living with HIV (PLHIV), LGBTQ+ individuals, and youth in low-income or rural areas.

Stigma leads to digital self-censorship, increased mental health risks, and disengagement from digital platforms, especially for those whose identities or health conditions face social stigma. Economic constraints prevent many from the digital world due to the high costs of devices, and data, further widening the digital divide and reinforcing cycles of poverty. Additionally, educational and cultural barriers restrict digital participation, breeding distrust of online platforms, and perpetuating exclusion, especially where societal norms limit the expression or use of digital tools.

Collectively, these challenges limit the young people’s participation in the digital age, restrict their autonomy and access to health information, and hinder progress toward equity and inclusion within the digital health ecosystem. It is crucial to tackle these barriers in a comprehensive manner to foster an inclusive digital landscape that respects the rights, dignity, and agency of all young people.

Recommendations

For Government and Policymakers

- Strengthen existing legal frameworks to provide effective remedies for survivors of online gender-based violence, ensure swift takedowns of harmful content, and protect sensitive data (e.g., HIV status, sexual orientation).
- Incorporate digital literacy and privacy education, customized for local contexts and cultural norms, into school curricula, national HIV prevention initiatives, and county development plans.
- Enhance access to digital devices for young people through interventions that make basic smartphones more affordable to the young people

For Civil Society and Health Organizations

- Co-create and disseminate youth-focused digital literacy content on SRHR, digital rights, and safety in local languages and formats appropriate for various literacy levels.
- Establish digital rights workshops and peer-led discussions to assist youth in managing privacy settings, navigating misinformation, and reporting abuse safely.

For Technology Companies and Platforms

- Take more responsibility in protecting users of their platforms through prompt action to reports of violations and strengthening their grievance redress systems.

For Donors and Development Partners

- Finance inclusive digital inclusion programs that integrate SRHR, digital literacy, and safety for young people, particularly those from marginalized populations.
- Support youth-led digital innovation and participatory research to identify scalable solutions to online stigma, exclusion, and misinformation.

3.2 Digital Safety and Privacy

Digital safety and privacy describe the ability to navigate the internet, use devices, and exchange information without undue risk of surveillance, coercion, or exposure. In Kenya, these conditions are shaped by pervasive data collection, uneven digital literacy, and fragmented legal or platform protections. As connectivity expands and smartphones become the primary gateway to accessing health information including SRHR, they also expose young people, and especially LGBTQ+ youth, those living with HIV, and young sex workers to new vulnerabilities.

Participants across all four counties reported how everyday digital activities including receiving clinic reminders, joining WhatsApp groups, or searching for health content, could result in blackmail, stigma, and social isolation. These threats are compounded by shared devices, unsecured networks, and opaque data practices. Young people reported the risks of involuntary outing, social isolation, psychological distress, and loss of income. This leads to avoidance of digital health services due to fear of being tracked or exposed. In this context, digital safety and privacy are not peripheral technical issues but central determinants of well-being, autonomy, and equitable access to care. Strengthening data protection, digital literacy, and accountability mechanisms is therefore critical to safeguarding young people's rights in an increasingly networked health landscape.

3.2.1 Surveillance (family and friend, private company and government)

Family, partner, or friend surveillance refers to the monitoring of a person's digital life by those in their immediate social circle (Mols, Campos & Pridmore, 2023). On the other end, private company surveillance is the systematic collection and analysis of personal data by businesses such as tech firms, social media platforms, and mobile providers primarily for profit, marketing, and service optimization (Christl, Kopp & Riecher, 2017). Government surveillance refers to the monitoring of individuals or groups by state authorities for purposes such as security, law enforcement, or political control, which can raise concerns about privacy, oversight, and human rights.

Overall, 58 participants described how risks inherent in phone sharing, fear of remote hacking, and unauthorized monitoring on platforms including WhatsApp, Facebook, and dating apps affected their participation in digital platforms. Tools like WhatsApp Web, app tracking, and national health or biometric systems were frequently cited. Young women, LGBTQ+ individuals, and persons living with HIV were often vulnerable to the intrusions resulting in involuntary disclosure of HIV status, sexual orientation, gender identity, and financial details. These breaches resulted in blackmail, stigma, emotional distress, denial of services and a withdrawal from digital health platforms. Surveillance concerns were consistently reported across gender identities and counties, but female participants contributed to nearly half of all the accounts, with Migori County reporting the highest number of cases and Nairobi showing the broadest diversity of surveillance actors.

> **"I had not disclosed my status, nobody knows if I'm HIV-positive or using these drugs... my friend gets my phone, accesses our groups, takes screenshots... people start isolating you, you become stigmatized... at long last some end up committing suicide."**
>
> 28-year-old female participant,
> Kitui (2024-KTU-FGD9-64)

> **"I had an ex, and I still had the number... I go on posting on Facebook as usual, memes and whatever. The next thing, someone posts a status; the way he puts it indicates I am the target... I could tell he was stalking me. I blocked him—if he wants to stalk, let him use a pseudo-account without me noticing.""**
>
> 24-year-old female participant,
> Migori (2024-MIG-FGD5-31)

County Findings

Young people in Kitui described a digital environment where privacy felt fragile and easily compromised. Casual sharing of phones often led to unintentional disclosure of HIV status or sexual orientation, leading to stigma and distress. Applications such as TikTok and [betting company] were viewed as tracking user behaviour, increasing concerns about ongoing surveillance. Simultaneously, government scrutiny, through biometrics, health records, and location tracking, was seen as widespread and unavoidable. Collectively, these overlapping threats left participants feeling insecure online and reluctant to pursue or disclose sensitive health information.

A 27-year-old male participant said;

> **“I came across my friend who wanted me to help him with my phone … after I helped him he started going through my messages and found the information I shared with the KP I was chatting with … he wanted to disclose this information to other people and I felt guilty … I found it not good to share your phone since the information in the phone is very sensitive and private.”**
>
> Male participant,
> Kitui (2024-KTU-FGD11-79)

> **“There is a time. A lady friend of mine was telling me, your guy is cheating on you. Bring your phone I teach you something simple, I will scan for you and you will be able to see everything he is doing. It did not take long. Everything that I was chatting on WhatsApp my guy was seeing it on his end. I really do not know how she connected my phone and his’’**
>
> 27-year-old female participant, Migori
> (2024-MIG-FGD5-33)
>
> ……
>
> **“I do share the phone sometimes with my family members. And you find that in the family, let me say, for instance, where one family member is living with HIV and AIDS, then the others, let’s say your cousin, nephew, don’t know about your wellbeing. Now sometimes you want to check on the issue, then you don’t want to expose it to your nephew or cousin, so somehow, you’re not comfortable with it. Now it makes you not use that time to seek information, so you find sometime when he/she is not around is when you want to seek the information from on the internet.”**
>
> 20-year-old male participant, Migori
> (2024-MIG-FGD6-43)

In Migori, young people described experiencing surveillance from various sources, including partners, family, digital platforms, and governmental systems. The practice of sharing phones and secret monitoring such as “phone scans” that replicated private conversations, created constant pressure to self-censure. Living with family members discouraged online health searches, particularly for those who are HIV-positive or exploring LGBTQ+ identities. Queries made on apps led to targeted content delivery, heightening concerns of being observed, while systems like Kenya EMR were perceived as susceptible to governmental access. These multiple layers of threats diminished confidence in digital resources and deterred young people from seeking sexual and reproductive health and rights (SRHR) services online.

Participants had this to say:

In Mombasa, the nature of surveillance was influenced by a combination of control from intimate partners, invasive applications, and anxieties surrounding government overreach. Even with widespread ownership of devices, young people, and particularly women and those in the LGBTQ+ community, reported that their partners employed strategies such as phone-tapping, password access, and connecting through WhatsApp Web to monitor and disclose private discussions. Applications requiring excessive personal data increased worries about potential misuse of information, while fears regarding government monitoring included concerns about financial control and the possibility of enforced disappearances. The convergence of these threats resulted in many feeling digitally unsafe and reluctant to search for sensitive health information online. Some female participants had this to say:

> **“The boyfriend tapped her phone … he was seeing everything on his phone and told her, ‘So you want to kill me with HIV’ … the boy knew everything by tapping the girl’s phone.”**
>
> 20-year-old female participant,
> Mombasa (2024-MSA-FGD16-106)

> **“When you go to the toilet and he knows your phone password, he will link it … if someone has linked my phone, they will see the messages sent to that group … that’s the end of her.”**
>
> 22-year-old female participant,
> Mombasa (2024-MSA-FGD16-105)

In Nairobi, young people reported the broadest spectrum of surveillance, which included monitoring from parents, scrutiny from peers, tracking by platforms, and oversight from the government. Despite having relatively high digital literacy, participants remained vulnerable to exposure. Tools like Google’s autocomplete, Snapchat notifications, and metadata from dating or health applications were perceived as means of involuntary outing, while parents and friends accessed search histories or observed online activities. Government surveillance was particularly concerning, as there were worries that personal information could be used to shame LGBTQ+ individuals or track searches related to health and sexuality. This complex landscape of surveillance created digital anxiety, restricted open engagement in online environments, and increased distrust in both private and public systems. Participants had this to say:

> **“When you log into Facebook there are many apps for people living with HIV … when you post something … somebody asks, ‘Are you also positive?”**
>
> 29-year-old female participant,
> Nairobi (2024-NBO-FGD4-25)

> **“My mother would access my phone … anything I was Googling; my parents would see … they discovered my sexuality through the internet.”**
>
> 29-year-old male participant,
> Nairobi (2024-NBO-IDI3).

3.2.2 Technology Facilitated Abuse

Technology-facilitated abuse (TFA) is defined as abuse that is committed, assisted, aggravated or amplified using internet and communication technologies or other digital technologies, that results in or is likely to result in physical, sexual, psychological, social, political or economic harm, or other infringements of rights and freedoms. It ranges from cyber-bullying, stalking, and account hijacking to blackmail and the non-consensual sharing of intimate images.

Overall, 53 young people described instances of online stalking, blackmail, account takeovers, cyberbullying, and non-consensual sharing of intimate content. Most reports came from female participants, but abuse spanned every gender identity and all the four counties, turning phones, public Wi-Fi, WhatsApp, Facebook, TikTok, and Twitter into spaces of danger rather than support. Harms ranged from involuntary HIV disclosure and public shaming to lost livelihoods and suicidal thoughts. Participants said;

> **“Yes. I say that someone might be using a phone at the same time you’re using it … If a hacker is using the same Wi-Fi I am using, he or she can hack my phone. So that when I’m using it, she’ll be also using it.”**
>
> 21-year-old male participant,
> Kitui (2024-KTU-FGD10-71)

> **“Also, when the information is leaked, it will lead to being abused verbally … that is going to hurt you emotionally and lead to suicidal thoughts.”**
>
> 21-year-old female participant,
> Nairobi (2024-NBO-FGD1-7)

County Findings

Young people in Kitui shared that HIV support groups and phone access can be weaponized, exposing private details and enabling blackmail.

> **“Some will create a group for all people living with HIV … you will be asked for a photo, age, gender, and the medicine you use … if the group is hacked they will spread information about you.”**
>
> 22-year-old female participant, Kitui (2024-KTU-FGD12-85)

> **“Maybe money? … If someone gets your phone, he will tell you to send 10,000/= or post what you always do … he will blackmail you … so you will be scared.”**
>
> 29-year-old female participant, Kitui (2024-KTU-FGD9-59)

In Migori, young adults shared cases of ex-partners using Facebook to track and harass them, forcing victims to block offenders and retreat offline.

> **“An ex … I go on posting on Facebook as usual, memes and whatever. The next thing, someone posts on status … it indicates that I am the target … that is when I decided to block him. And if he wants to stalk, let him use a pseudo-account.”**
>
> 24-year-old female participant, Migori (2024-MIG-FGD5-31)

In Mombasa, participants shared how relentless cyberbullying on social media silences sexual-health discussions and even drives users off platforms.

> **“I’m speaking about cyberbullying … you find someone who comes and tells you, don’t talk about this … the more you want to give information out there, there are people who will lower your self-esteem … that’s why most people like us, we don’t like going online and talking about these things…… People started talking, ‘you have a few days to live’ to the point that I closed my account.”**
>
> 24-year-old non binary participant, Mombasa (2024-MSA-FGD14-92)

3.2.3 Poor Data Protection

Poor data protection describes an environment where personal information is collected, stored, and shared without clear safeguards, user consent, or effective oversight.

From the discussions, 46 young people described how weak data safeguards expose their health, identity, and creative work online. Across the board, poor data protection was seen as a key enabler of digital surveillance, technology-facilitated abuse, stigma, and unwanted exposure. Participants pointed to unchecked third-party data sharing, the impossibility of tracing how their information is used, and the absence of clear channels for reporting breaches. Unsecured SMS reminders that reveal HIV status, auto-filled sensitive searches, and leaked creative content all highlighted how privacy failures erode trust in digital services and public systems.

> **“If the government can’t access my information through me, they will go to the private companies…It is a telecommunication company, yes, so the government will get my information, all that they want through telecommunication company,”**
>
> 30-year-old non binary participant, Mombasa (2024-MSA-FGD14-94)

County Findings

Young people in Kitui shared how weak data safeguards can let even big organisations leak private information, and they urged public education and the right to sue over privacy breaches.

> **“I think the public should be educated on the matter of privacy … no one should leak your privacy without your consent … you have the right to sue the person who leaks your information.”**
>
> 23-year-old Male participant,
> Kitui (2024-KTU-FGD10-70)

Young people in Migori shared concerns of how when they exchange messages online, anyone who gets your phone can read and spread them, underscoring how little privacy protections exist on popular platforms.

> **“Yeah, at times it is a risk because when you chat online you remain with their data, and they also remain with your data … there is insecurity on online platforms and lack of privacy … I don’t know how many people he has shown our chats.”**
>
> 22-year-old male participant,
> Migori (2024-MIG-FGD7-48)

In Mombasa young people shared how weak data protections allegedly let hostile users mass-report TikTok accounts.

> **“See, if a person doesn’t like you on TikTok, it’s very easy; she will just decide to report your account and tell her friends to do the same … I feel like they should have more measures—there should be a clear process.”**
>
> 25-year-old female,
> Mombasa (2024-MSA-FGD13-86)

Young people in Nairobi shared how unexpected job offers and financial alerts can appear without consent, raising concerns that apps pass their data to third parties and manipulate accounts.

> **“Yes. … whenever I sign up to this app, later I find ‘your application has passed through,’ and I know very well I did not apply for any job. Or I get funds in a Bitcoin account—yet I do not have a Bitcoin account. … Anything written there will be shared with a third party. I did not accept; I did not consent.”**
>
> 26-year-old male participant,
> Nairobi (2024-NBO-FGD3-21)

Implications

Findings from all four counties indicate that violations of digital safety and privacy are not merely technical challenges, but are systemic barriers that impede health, safety, and autonomy for young individuals, especially those from marginalized groups. Surveillance, inadequate data protections, and technology-facilitated abuse (TFA) interplay in intricate ways to undermine trust, limit behaviour, and discourage engagement with digital health services.

Surveillance by family members, partners, and peers, often through shared phones or discrete observation, resulted in unintentional disclosure of sensitive personal information, such as HIV status, sexual orientation, or gender identity. These breaches triggered stigma, social exclusion, and mental health challenges, particularly for women, LGBTQ+ youth, and people living with HIV. Government surveillance and especially concerns around biometric databases, KenyaEMR, and SIM card registration, hindered open searches for SRHR content. The fear that the same government offering services could also penalize users fostered widespread self-censorship and disengagement, especially among groups facing legal or social persecution.

The data-centric approaches of private companies’ exposed participants to unwanted visibility through targeted advertisements, autofill suggestions, and contact syncing. These subtle yet intrusive nuances reinforced perceptions of constant observation and deepened distrust in mainstream platforms.

Technology-facilitated abuse such as blackmail, account hacking, and cyberbullying has intensified the psychological toll. Many participants reported experiencing fear, anxiety, and social isolation. Some opted to disengage from online spaces altogether, undermining efforts to expand access to digital SRHR services. Insufficient digital protections are widening the digital divide, not just in terms of access, but in safety, confidence, and freedom to participate. Instead of promoting empowerment, digital platforms lacking adequate safeguards turned into sites of surveillance and harm for the most marginalized youth.

Recommendations

For Government and Policymakers

- Strengthen and enforce the Data Protection Act to address surveillance, biometric misuse, and algorithmic profiling. Legal reforms should close loopholes that allow non-consensual data sharing and unauthorized monitoring.
- Develop legal recognition for interpersonal digital surveillance (e.g. by family or intimate partners) as a form of technology-facilitated abuse and integrate this into digital safety and gender-based violence frameworks.
- Ensure that public health communication tools, such as SMS alerts or digital health platforms, include strong privacy safeguards and do not inadvertently disclose sensitive information.

For Civil Society and Health Organizations

- Deliver targeted digital literacy and privacy training, particularly for marginalized youth, covering topics like data protection, recognizing online threats, and securing devices.
- Raise awareness and advocate for comprehensive digital safety policies that reflect the lived realities of young people—including surveillance within homes, schools, clinics, and peer groups.

For Technology Providers and Platforms

- Take more responsibility in protection of data of users of their platforms, for instance, embed privacy-by-design principles into apps and services, including encrypted messaging, private modes, opt-in consent, and clear data-sharing settings.
- Establish rapid-response systems to address digital abuse, including mass-reporting, account hijacking, blackmail, and exposure through social media features like autofill and contact syncing.
- Ensure transparency in data use, including clear disclosures on third-party sharing, data retention, and how content is personalized or moderated.
- Provide users with real control over their digital footprint, including the ability to easily review, delete, or limit personal data and to opt out of tracking features.

For Donors and Development Partners

- Promote cross-sector collaboration by facilitating partnerships between government, tech companies, health providers, and youth groups to co-create inclusive digital safety policies and programs.

3.3 Digital Awareness and Empowerment

Digital awareness and empowerment among young people in the context of health and rights refers to the ability to access, understand, and make use of digital platforms for health-related information, all while safeguarding one's rights and wellbeing in online environments. This concept goes beyond the basic access to also include the skills needed to navigate technology effectively, make informed health decisions, and exercise agency in digital environments. As digital tools become increasingly available, especially among young people in Kenya, digital engagement has emerged as a primary method of obtaining sexual and reproductive health (SRH) information. However, this engagement is influenced by various social, economic, and structural barriers, including stigma, surveillance, misinformation, and unequal access, which disproportionately affect key populations such as young people living with HIV, LGBTQ+ individuals, and young sex workers.

Digital awareness can be divided into three interconnected components: digital literacy, which involves navigating digital tools and platforms; digital health literacy, which involves finding, interpreting, and utilizing digital health information; and digital rights and security literacy, which pertains to understanding online rights, privacy, and data protection. While digital spaces provide youth with a means of autonomy and empowerment, this study reveals that many still encounter digital exclusion, unsafe environments, and limited participation in shaping the tools that impact their health. Therefore, meaningful investment in these three areas is crucial in promoting equity, inclusion, and agency among Kenya's digitally connected yet underserved youth.

3.3.1 Digital Literacy

Digital literacy is the basic ability to use digital tools and platforms effectively. For young people navigating sensitive health issues such as HIV and SRHR, digital literacy is more than a technical skill, it is an essential enabler of access, participation, and expression in an increasingly online world. In the absence of these skills, youth find it difficult to safely seek health information, engage in peer learning, or safeguard themselves from digital harms.

Overall, digital literacy-related barriers were prominent as over 40 participants noted this as a crucial barrier to digital engagement. These included difficulties with device use, navigating online content, identifying credible health sources, and engaging in safe online practices. It is important to note that the weight of these challenges was more pronounced among male participants and those residing in Kitui and Migori counties, highlighting the need for tailored digital skills training. However, urban youth also expressed anxiety about online judgment and surveillance, particularly among female and LGBTQ+ youth.

> **"The fundamental one is about literacy, about the devices and Internet access... you can't teach someone about privacy if they don't know how to navigate the system properly."**
>
> 27-year-old female participant, Kitui (2024-KTU-FGD9-65)

> **"You'll research something. Maybe you are, you are going through a certain kind of disease or illness. You'll just go online. You get to a site and search or Google the symptoms or anything. You'll not remember to delete the history. All your... everything you're doing online will be there in case someone asks for your laptop or your phone to do something they're able to get to know like what you were previously doing. And maybe what if you're using a company laptop or using a cyber? So, you see, uh, every time you get online, you get, what you are looking for .... If you're looking for a job, if you're looking for somebody, all this data will be just there only. And it's breaching your privacy. So, people will be knowing what you go through and what you intend to do in your everyday life."**
>
> 29-year-old female participant, Mombasa (2024-MSA-FGD13-88)

County Based Findings

Despite a relatively high number of digital literacy barriers, many young people in Kitui demonstrated basic familiarity with smartphones and social media but struggled with deeper digital competencies. The young people relied on others for information and found it difficult to verify the credibility of online health sources. One participant shared,

> **“When I’m getting to a WhatsApp group, I always check their description, what is written there if it’s health education, hook-ups, or trends. So, you must check the description. On the side of the privacy on my side. It’s difficult for me when I am doing sensitization on HIV sensitization since I was doing it on WhatsApp group. People think they always assume ‘this person is infected’ and then they start spreading false information. So, there is a problem when doing sensitization in the groups.”**
>
> 23-year-old male participant, Kitui (2024-KTU-FGD10-68)

In Migori, young people reported moderate barriers stemming from fear, misinformation, and technical difficulty, compounded by stigma and limited digital learning opportunities and exposure to verified digital health platforms. A participant mentioned,

> **“It should be physical because you cannot teach a person on Zoom, and they don’t even know how to operate Zoom. So, the basic ones should come first.”**
>
> 25-year-old female participant, Migori (2024-MIG-FGD5-34)

Although digital tool access was comparatively higher in Mombasa, participants reported relatively lower barriers, with concerns centered on misinformation and online hostility. One participant noted:

> **“Some of the sites where we’re going to access this information… online has a lot of information and you might not know which is the right source you’re clicking into. Some of the links… might have viruses, or they might be phishing accounts… which will interfere with your information.”**
>
> 29-year-old female, Mombasa (2024-MSA-FGD13-88)

With the lowest reported digital literacy barriers, Nairobi’s young people tend to be more digitally savvy but still face privacy related concerns, especially amongst the stigmatized groups. One participant shared:

> **“When you log into Facebook there are many apps for people living with HIV. When you join those apps, you find that, you ask yourself, in this app is everybody positive? So, when you post something or you ask a question, you find somebody asking you, are you also positive?”**
>
> 29-year-old female participant, Nairobi (2024-NBO-FGD4-25)

Another participant had this to add:

> **“Online platforms are both helpful and dangerous—people can access your phone, see your search history, and judge you for it.”**
>
> 22-year-old male participant, Nairobi (2024-NBO-FGD2-14)

3.3.2 Digital Health Literacy

Digital health literacy builds upon general digital literacy by focusing on the ability to find, understand, evaluate, and apply online health information. In the context of sexual and reproductive health and rights (SRHR), it involves navigating apps, websites, and social media to access services like PrEP, STI information, and mental health support. However, misinformation, platform censorship, and fear of judgment often compromise young people's ability to benefit from digital health tools. This section offers perspective on how young people engage with digital health information and the barriers they encounter in making informed health decisions.

Digital health literacy remains a major challenge for young people, as over 43 participants spoke about it. Many young people rely on platforms like TikTok and Facebook for health content, yet struggle with misinformation, judgment, or inability to discern reliable sources. In Nairobi and Mombasa counties digital health literacy was reported as a crucial barrier, with trans and non-binary individuals facing unique vulnerabilities due to stigma and lack of representation in digital health ecosystems.

County Based Findings

In Kitui, digital health literacy barriers were moderate, and were shaped by stigma and poor access to verified online health content.

> **"Maybe, on the point of illiteracy. Maybe you are googling something like drugs, and you get a response, but you don't understand it. Or a person tells you where you are going to meet but you don't know how to read, something like that. "**
>
> 29-year-old female participant (2024-KTU-FGD9-59)

Migori participants reported issues ranging from fear of online judgment to lack of accurate information. One young participant noted:

> **"For example, you might have a point that you want to discuss with other people, but you fear talking to this people online and feel like if I say my point, they will have a certain perception about me. Or even I post it on social media, maybe 2024-MIG-FGD5-36 knows me as 2024-MIG-FGD5-34, I may be exposed."**
>
> 24-year-old female participant, Migori (2024-MIG-FGD5-35)

Young people in Mombasa demonstrated significant concern about harassment and misinformation online, leading to self-censorship.

A participant stated:

> **"Maybe I log into TikTok just like 2024-MSA-FGD16-106 has mentioned, someone who has accepted her status tells her story on TikTok, but people are different because maybe she has accepted herself because she underwent training. So, I log into TikTok and see she has shared her story when I go to the comments, I see how she is being abused and I tell myself if I go there and look for this information, I will also be abused so I end up not opening up. I just continue keeping it a secret."**
>
> 22-year-old female participant, Mombasa (2024-MSA-FGD16-105)

Nairobi participants reported the highest number of digital health literacy barriers with the environment reflecting an advanced platform usage but heightened risks.

One respondent said:

> **“Privacy. Maybe let’s say 17 to 18 years old AGYW and I fear that if I try to ask for such and such a medicine through phone maybe they will start judging me. Like, they will be like, ‘What’s your age?’ Then I say I’m 18 years old. And they’ll ask, ‘Why do you want to get—let me give an example—maybe PrEP.’ I want to take PrEP. Ahh, they will just start asking me. So I’m like, I’m just afraid. How will I explain these things yet I want to access that medicine? So I feel like my information is not secure. The fear.”**
>
> 20-year-old female participant, Nairobi (2024-NBO-FGD1-3)

3.3.3 Digital Rights and Security Literacy

Digital rights and security literacy involves understanding one’s rights regarding privacy, data protection, and safe expression online, as well as possessing the knowledge to protect oneself against digital surveillance and exploitation. For young people belonging to marginalized groups such as LGBTQ+ youth or those living with HIV, this understanding is crucial in protecting one’s personal information and preventing exposure to stigma, violence, or legal consequences.

Across all counties, the participants highlighted critical gaps in understanding digital rights and data security, as reported by 29 participants. Fear of surveillance, data misuse, and exposure of private information especially for key populations such as LGBTQ+ youth has created a culture of self-censorship and digital retreat. Nairobi and Kitui recorded the highest counts of concern, emphasizing the need for rights-based digital education.

> **“They can access Grindr, Tinder, all those platforms… then use that data to profile you. This is not privacy. It’s surveillance.”**
>
> 20-year-old female participant (2024-NBO-FGD1-3)

County Based Findings

In Kitui, young people’s fears of being exposed through digital footprints was dominant, as well as privacy breaches, especially through shared devices. One respondent shared:

> **“Okay. The only thing that people need to know is that on the internet there is what you call security. There is a feature called two-factor verification. So, people need to just be educated about security issues whereby you need that feature like security verification so that your information is just secure. So, the only challenging thing is people don’t know security issues on the internet. Because they are there.”**
>
> 24-year-old male participant, Kitui (2024-KTU-FGD10-66)

Migori reported the lowest number of digital rights and literacy issues, but even here, the implications were still serious and particularly around secure practices and the risks associated with public access points. A 28-year-old female participant had this to say,

> **“For example, I am HIV positive, and I help my friend with my phone, and she finds messages of me talking to my doctor about how I can get drugs she might disclose my status to other people. And this happens to some people. So, it is the most challenging.” She went on to add this: “I share my smartphone with my friend and there is insecurity because sometimes she reads my messages, and WhatsApp, and logs into my Facebook account. And then sometimes when her mother finds out that I gave her the phone, it brings up a lot of issues”**
>
> 28-year-old female participant, Migori (2024-MIG-FGD8-56)

A similar concern was shared with yet another participant:

> **“Yeah, I wanted to support that because sometimes sharing phones like maybe you haven’t disclosed to their family. And you receive a Ushauri prompt, tomorrow is your appointment. Now, they will start asking which appointment this is. We haven’t seen him in any meetings. Yeah.”**
>
> 29-year-old male participant, Migori (2024-MIG-FGD6-41)

In Mombasa, the youth raised concerns about sharing of personal devices, surveillance, and the consequences of data breaches. One participant stated:

> **“You’ll research something. Maybe you are, you are going through a certain kind of disease or illness. You’ll just go online. You get to a site and search or Google the symptoms or anything. You’ll not remember to delete the history. All your… everything you’re doing online will be there in case someone asks for your laptop or your phone to do something they’re able to get to know like what you were previously doing. And maybe what if you’re using a company laptop or using a cyber? So, you see, uh, every time you get online, you get, what you are looking for ……. If you’re looking for a job, if you’re looking for somebody, all this data will be just there only. And it’s breaching your privacy. So, people will be knowing what you go through and what you intend to do in your everyday life.”**
>
> 29-year-old female participant, Mombasa (2024-MSA-FGD13-88)

Nairobi participants reported surveillance from both individuals and institutions as well as loss of autonomy. This was especially pronounced among LGBTQ+ youth.

> **“There was a time when we heard that the government had started spying on people on Google so people should use Chrome…. So, people would search on Google and get results but now they are not available because the government got involved so people are like if the government can access and know all of my Google history. And during that time there was anti-LGBTQ so with that most of the community members are scared of searching health-related issues because they might search anal warts and the government is watching. (laugh).”**
>
> 27-year-old male participant, Nairobi (2024-NBO-FGD3-16)

Implication

The findings point to critical vulnerabilities that hinder young people’s ability to safely and effectively engage with digital tools for health and rights. While many young people demonstrate a willingness and need to use digital platforms, gaps in digital literacy limit their ability to navigate platforms safely and critically. Digital health literacy is frequently undermined by misinformation, confusing content, and lack of credible sources, while digital rights and privacy violations including surveillance, data breaches, and peer monitoring, undermine trust in digital spaces.

The risks associated with digital inequality are disproportionately borne by young people from marginalized communities, including those who are living with HIV, LGBTQ+ youth, and young people in rural or low-income settings. Stigma, economic barriers, gender inequalities, and a lack of culturally appropriate content further worsens these challenges. If urgent and targeted measures are not taken, these digital inequalities could widen existing health and rights inequities, increase social exclusion, and undermine trust in digital health systems. Thus, digital empowerment is not just a technical or educational issue, but a matter of health equity, youth agency, and human rights.

Recommendations

For Government and Policymakers

- Develop and enforce national digital literacy and digital health education curricula tailored to young people, with a focus on accessing health information and services including SRHR.
- Strengthen data protection laws and mechanisms for reporting digital rights violations, particularly in health-related platforms.

For Civil Society and Health Organizations

- Co-create digital health literacy content with youth, especially from underserved populations, especially LGBTQ+ youth, adolescents living with HIV, and rural communities, to ensure contextual relevance and accessibility.
- Provide safe digital spaces for youth, including moderated forums, peer support channels or helplines for youth to access accurate SRH information without fear.
- Train peer educators and community based “digital navigators” to help youth assess online health information critically and securely.

For Technology Providers and Platforms

- Partner with youth-led and rights-based organizations to design safer, stigma-free digital environments that promote health and rights.

For Donors and Development Partners

- Fund initiatives that integrate digital literacy, digital rights, and online safety as part of broader adolescent and youth sexual and reproductive health (AYSRH) programs.

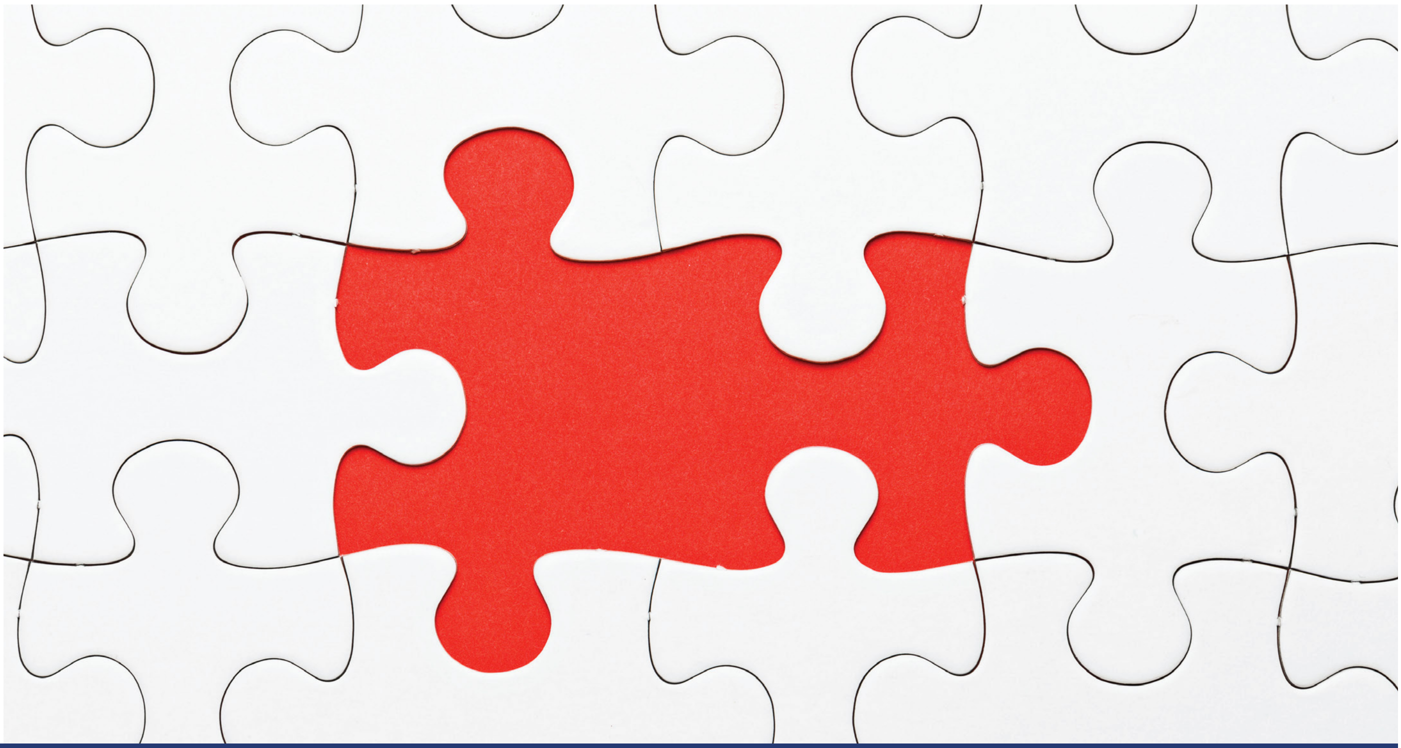
3.4 Community response

Community-led response refers to actions initiated and organized by community members or leaders to address local needs, challenges, or crises, often without formal support from external institutions. In this context, community members/leaders used social media platforms such as WhatsApp and Facebook to share important information about health, legal rights, and social services. These digital tools enable rapid, peer-to-peer communication and help mobilize support, spread awareness, and foster collective action, especially in contexts where access to formal resources is limited.

In rural setup, community-led responses among key populations (KPs) are built on close-knit peer educator networks that combine face-to-face outreach with cautious use of digital tools. Due to high levels of stigma and limited-service access, peer educators work discreetly to offer health information and psychosocial support. WhatsApp and mobile apps are used to share resources like PrEP and PEP guidance and to connect people with clinics, though privacy concerns persist. To safeguard identities, some community members maintain multiple phone numbers or advocate for anonymous service systems.

In peri-urban setup, peer-led digital engagement flourishes across WhatsApp, Facebook, and Instagram, where KPs form support groups to exchange health information, coordinate outreach, and destigmatize HIV. Campaigns like U=U circulate rapidly, especially among youth, while localized WhatsApp groups foster emotional support and practical advice on managing side effects. Vetting processes are used to prevent bad actors in online spaces. Peri-urban outreach also targets hidden KPs by meeting them in their homes or designing community-based platforms tailored to their needs. Trust, safety, and a deep sense of solidarity underpin this model of community care.

In urban setup, digital platforms are central to KP advocacy, coordination, and political engagement. Youth-led campaigns on X, TikTok, and Instagram amplify LGBTQ and HIV-related rights, while WhatsApp groups offer rapid communication for everything from medication shortages to social support. However, stigma and data privacy concerns still surface, with some avoiding HIV-related groups to protect their status. Digital literacy training is increasingly recognized as vital, particularly among young people navigating online risk. Community leaders and advocates emphasize self-advocacy, resilience, and the necessity of representation in policy making spaces to ensure their voices are heard.



4.0 Conclusion and recommendations

This study illuminates the complex interplay of opportunities and challenges facing Kenyan youth in the digital age, particularly in accessing health information and services especially sexual and reproductive health and rights. The findings reveal that while digital platforms offer significant potential for empowerment, persistent barriers—stigma, economic constraints, educational and cultural limitations, surveillance, technology-facilitated abuse, and poor data protection—disproportionately hinder marginalized groups, including people living with HIV (PLHIV), LGBTQ+ individuals, and sex workers in accessing health information and services. These barriers not only restrict access to digital health tools but also undermine autonomy, privacy, and safety, perpetuating inequities in Kenya's digital ecosystem.

The participatory action research (PAR) approach, conducted across Nairobi, Mombasa, Kitui, and Migori, underscores the critical role of youth voices in shaping digital governance. Participants highlighted how stigma drives self-censorship, economic barriers limit device and data access, and low digital literacy exacerbates misinformation and privacy risks. Surveillance, whether by family, peers, or government, and technology-facilitated abuse further erode trust in digital platforms, particularly for key populations. Despite these challenges, community-led responses through peer networks, WhatsApp groups, and advocacy campaigns demonstrate resilience and innovation in addressing digital exclusion and promoting rights-based solutions. The implications of these findings are crucial for policy, practice, and research. To foster an inclusive digital landscape, Kenya must prioritize rights-based governance that integrates digital literacy, privacy protections, and youth participation. Recommendations include strengthening data protection laws, co-creating youth-focused digital literacy content, and embedding privacy-by-design principles in health platforms. Civil society, technology providers, and donors play crucial roles in supporting these efforts through targeted training, safe digital spaces, and funding for youth-led innovations.

Looking forward, this study calls for sustained investment in digital equity and human rights, drawing on the HIV movement's lessons of community-led advocacy. Future research should explore scalable solutions to digital harms, such as online harassment and misinformation, and evaluate the impact of community-led digital initiatives. By centering youth as active participants in digital governance, Kenya can harness its digital revolution to advance health equity, inclusion, and empowerment for all its young people, ensuring that no one is left behind in the digital age.

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Appendices

Appendix I: Key Informant Interview Guide

Introductory Questions

1. Please describe your professional role and your previous background and training
2. Do you work on digital/AI governance in your professional role, and if so, Please describe?
3. Our project focuses on groups that the World Health Organization calls key populations (people living with HIV, sex workers, gay men and other men who have sex with men, transgender people, people who use drugs). Do you work with key populations in your professional role, and if so, Please describe?

Digital divides:

- Can you please describe how young adults, especially key populations, use mobile phones in your country/community of work?
  - *Examples: to access health information, to locate clinics, for telemedicine appointments, to mobilize online support groups, etc.*

- What are some of the challenges young adults have in accessing smart phones, airtime and navigating online? Please relate the challenges to specific platforms (smart phone, airtime and internet).
  - *Are the challenges different based on*
    - gender?
    - geographic regions (rural, peri-urban, urban)?
    - language/ethnicity?
    - Migration status?
    - Cost?
  - *If yes, can you give some concrete examples of these differences?*
  - *How does your [organisation/…] account for these diversities when addressing the digital divides*

- Are there differences in access to online spaces for people living with HIV and key populations?
    - If so, which populations?
    - What are the differences you have observed?

- Are there specific security threats that young key populations face when going online?
  - *Can you share examples you have either experienced directly or heard about?*

- Are you aware of laws that criminalize that criminalize and marginalize key populations? If yes, can you mention them?
    - How do these existing laws affect what happens to key populations when they go online to seek health information and services?
    - Are you aware of any debates or concerns among key populations groups about real or imagined government surveillance online?

  - *If so, can you give examples?*
  - *Do you believe the concerns are well-founded? Why or why not?*

- Are there initiatives in place that seek to address the digital divide and what success are they having in 'reaching the last mile'
  - Can you name some of them?
  - How are they funded?

Digital governance:

- Which government agency/ies are responsible for digital/AI governance for health in the country?

- Do you know any current policy/laws that regulate digital/AI governance in the country?

- What do you see as the strengths and weaknesses of the current policy framework for digital/AI governance in [Colombia/Ghana/Kenya/Vietnam]?
  - What are some gaps that need to be addressed in laws and policies?
  - What are gaps that need to be addressed in enforcement/implementation of the laws and policies that already exist?
  - Where are the gaps in coordination among government departments and/or (development?) agencies?
  - What are gaps to address in public awareness?

- Are there opportunities to strengthen that framework (e.g. new laws, policies, strategies under development, new agencies, high-level summits, etc.) in the coming year?
  - If yes, can you describe more about these opportunities?
  - If no, what do you think will be the opportunity to strengthen that framework?

- Have you participated directly in these governance discussions?
  - If so, what is the current focus of these discussions?
  - In your view, is the focus on the right problems?
  - Have you found anything especially encouraging or challenging about the way these discussions are going?
  - Who leads these governance discussions (e.g. Ministry of Health, Vice President's office, UN agencies, private sector, overseas development assistance agencies, the World Bank...etc.)?
  - *In your view, are the right actors at the table – is anyone missing?*
  - Have young adults been represented in these governance discussions, and if so, how?

- Is there normative guidance you find helpful in advocating for more effective digital/AI governance (e.g., ethical principles, UN guidance, regional governance reports, etc.)?
  - What kind of guidance do you wish you had, but have not been able to find?

- Are the issues we discussed earlier facing key populations, women, rural populations, and others likely to be addressed in governance of digital health and AI?
  - Why or why not?
  - What are the barriers, if any, to addressing the challenges these groups face with online access and participation? Can you describe these barriers?

- Are you aware of any entry points or opportunities for young adults to participate in digital / AI governance policy-making processes in the coming months?

Meaningful participation

- Have you been part of any policy-making processes on digital governance/AI that included consultation with young adults?
- If no, why do you believe they were not included?
    - What would have been helpful to facilitate their participation?
- If yes, please describe the process and how young adults participated.
    - Who organized the policy-making process (e.g. government agency, private foundation, UN agency, etc.)?
    - How were the young adults who participated identified?

Meaningful participation

Optional questions, to be used based on populations and context

- Are you aware of any proposals before the government right now to address how digital technologies are governed (such as an ehealth bill, digital health strategy, AI regulation...)?

- Have you been part of any policy-making processes on digital governance/AI that included consultation with young adults?

- If yes, please describe the process and how young adults participated.
    - Who organized the policy-making process (e.g. government agency, private foundation, UN agency, etc.)?
    - How were the young adults who participated identified?
    - Were they representative of young adults from diverse backgrounds and groups, or was it a fairly homogeneous group?
    - Did they represent youth-led or youth-focused networks/organisations?
    - What was the nature of their input (participation in meetings, consultations, written submissions, organizing panels, etc.)?

- Were there any risks for young people who participated in the process? (for instance, safety while traveling, harassment during the meeting, risk of retaliation for criticism, exposure as living with HIV or key population, etc.)
    - If yes, were the risks assessed by the organizers of the process?
    - Were actions take to mitigate the risk?

- Were young people's views listened to during the process?
    - Was it clear what level of influence the young people who participated had on the process?
    - Were young people involved from the beginning in designing the process?
    - Was there enough of a budget to support young people's participation?
    - Were young people engaged using their diverse skills and experience?

- Were the right young people in the room to represent the issues being discussed?
    - Were those engaged actually people with relevant experience and knowledge?
    - Were diverse young people represented?
    - Was translation supported, if it was needed?
    - Were youth-led organizations supported to participate?

- Were young participants appropriately compensated for their time and for the costs of participation?

- Was there opportunity for young people to engage effectively and build their networks, skills and partnerships?

- Did you hear any other feedback from participants about how well the whole process worked?
    - Any lessons learned from this experience about how best to ensure meaningful participation of young adults in digital/AI policymaking?

Digital literacy and empowerment

- What does digital literacy mean to you? or your community?

- Does digital literacy differ from digital health literacy? If so, how?

- Have you heard the phrase "digital empowerment"?

- What do you think it means, or should mean?
    - Similar to digital literacy, or different?

- Do you have any preference between the terms digital literacy and digital empowerment?
    - If so, which do you prefer, and why?

- What are the key skills, knowledge, behaviors you believe young people need when going online to seek health information, services and support? (for example, technical skills, language skills, ability to read technical information, ability to judge misinformation, security skills, critical thinking... etc.)

- What are the key skills, knowledge, behaviors you believe young people need in order to participate meaningfully in digital/AI governance discussions?

- Have you seen or participated in any digital literacy/empowerment training for young adults and/or key populations?
    - If yes, please describe it

- Was it a good model?
    - Why or why not?

- How was it funded?

- Who (government department or other actor) should be responsible for delivering digital literacy?

Appendix II: FGD discussion guide

Relevant research questions:

- How do young people experience multiple digital divides (e.g. gender, race, sexual orientation, nationality, language, socio-economic class, and geography, among other factors) as intersecting to shape their empowerment or disempowerment?
- How do populations who are criminalised and stigmatised (including LGBTQ+ people, sex workers, migrants and young PLHIV) experience the risks and realities of state surveillance in the digital transformation?
- What kinds of digital literacy and empowerment do young people and communities need and want?
- What is the future of human rights in the digital world, and what role can diverse grassroots communities in LMICs play in shaping that future?

Note about the FGD Discussion Guide:

These questions are for FGDs to be held with people living with HIV and key populations in rural, urban and peri-urban regions of each country. The FGDs will be recorded and transcribed for analysis. Each national team will aim to interview at least three different key populations groups, and to hold FGDs in two different areas of the country, including urban, rural and periurban areas.

Participants will be anonymized and intake data will include only pseudonym, age (18-30 y.o.), employment, and gender identity (male, female, queer, non-binary, transgender, other, or prefer not to say). Information used to recruit study participants will be kept separately and not linked to the data.

We agreed that researchers may know that some groups include sex workers or people who use drugs, and where this is known and shared with the researcher in advance, the FGD may be flagged and coded as sex workers or people who use drugs, but in keeping with our data protection and anonymity commitments, we will not ask people to identify as such we do the intake.

The FGDs should take approximately 90 minutes.

1. Please introduce yourselves to the group with your pseudonym, and one fun fact to share about you. Please remember to use your pseudonym when you speak, so when we listen to the recording, we know who was speaking.
2. Gallery walk exercise (should take 20-30 minutes total):

   Please take a moment to describe (facilitators can write for those who cannot write) or write on a post-it some examples of things that make it difficult for you and people you know to access health information and services online, or to share it with others.

   Note: If people are struggling to think of anything, possible issues could include: lack of airtime, lack of privacy, gender identity different from one assigned at birth.

   Give participants 5 minutes to write these down and invite them to stick them on the walls. Group issues together that are related as participants put them up. Once the post-its are all up on the wall and grouped together by topic, discuss as a group what some of the different post-it notes relate to (not necessary to discuss each one). Remember to ask people to identify themselves by pseudonym when they speak, for the recording.

3. When was the last time you felt blocked from getting online to do something you needed to do for your health because of one of the issues on the wall – can you share what happened?
4. Looking at what we have put on the wall, what are the main issues affecting online participation for different genders? How would you rank them? Did we miss anything?
5. Looking at what is on the wall, what are the main issues affecting online participation by PLHIV and key populations (Sex workers, LGBTQI+)? Did we miss anything?
6. Are some of these issues more a concern for one population group than another one, and if so, why?
7. Have you ever felt like you're being watched or that your data is being tracked when you use apps your phone? If yes, can you share more about that? What did you notice, is it based on experience or things you know (media) or others have said it to you? Why do you think it happens?
8. Are there benefits of companies, agencies and organisations having your information without your knowledge, and if so, what are they?
9. What are the risks?
10. Have you ever experienced being denied a service by the use of a tool or app, if so, what happened? How do you perceive the use of tools in everyday decision making?
11. We are increasingly being asked to share biometrics (such as fingerprints, faces, etc.) to verify our identities. What is your view on this?
12. Can you give an example of anyone who has had to take any special measures to stay safe online? Why?
13. Which government agencies do you believe are responsible for overseeing mobile phone apps and websites in (Colombia/Ghana/Kenya/Vietnam)?
14. If you had a chance to participate in their decisions, what would you need to know to participate?

Appendix III: In-depth Interview Guide

Note about the FGD Discussion Guide:

These questions are designed for specific participants in the FGDs whose participation in the FGD indicates that they have more to share on their unique experiences which may not be shared within a FGD setting, either due to time constraints or other factors. Researchers will identify such individuals and invite them to individual interview sessions, obtaining informed consent. Data collection and analysis will follow strict ethical principles detailed in the research protocol. The list below is indicative only for a semi-structured interview, and researchers should follow the specific topics highlighted by the individuals in the FGDs rather than a rigid sequence of questions.

Introductory Questions

1. Can you please share the pseudonym you picked in the FGD just now?
2. Can you please share a bit about yourself, anything you would like to share or think we should know?
3. We are interested to hear some more about your experiences and insights, as shared in the FGD just now [*Choose one of the optional topics below]*

Optional topic: Political determinants of digital health

- What are some of the challenges you or people you know have in accessing smart phones, airtime and navigating online?
    - Interviewer: Probe to explore whether challenges relate to;
        - Family norms and cultural norms about the different roles of men and women
        - Access to internet in your region
        - Cost of smartphones
        - Cost of airtime
        - Language differences
        - Citizenship or legal status

- Have you ever experienced being blocked or denied a service through a tool or app? Can you share your experience?

- Do you think access and online experiences are the same for everyone, or do some people have better

- As you heard in the FGDs, our project focuses on groups that the World Health Organization calls key populations (people living with HIV, sex workers, gay men and other men who have sex with men, transgender people, people who use drugs), as well as people in displacement. Are there differences in access to online spaces for people living with HIV and key populations?
    - If so, which populations?
    - What are the differences you have observed?

- Are there specific security threats that young key populations face when going online?
    - Can you share examples you have either experienced directly or heard about?

- Are you aware of laws that criminalize behaviors of key populations or drive them underground? If yes, can you mention the related laws/sections/articles?

- Do these laws have any effect on key populations when they go online to seek health information and services?
    - Are you aware of any debates or concerns among key populations groups about real or feared online surveillance of criminalized key populations?

  - If so, can you give examples?
  - If there are concerns, do you believe they are well-founded? Why or why not?
  - Do you share these concerns?
  - If yes, how do they affect your choices when you go online? Do you feel you need to be more careful, or need to take steps to protect yourself?

- Do you think the digital platforms you use have mechanisms that protect you from harm?

- What would you require to help you protect yourself from harm when you go online or utilise services on digital platforms?

- In the future, who should be responsible for making online spaces safe for you and people you know? How would you want this to be done?

- Do you have any additional experience you would like to share? Please explain.

Optional topic: Meaningful participation in digital governance

1. Can you reflect on any experience you have had in advocacy and lobbying about digital health and rights in the past? Please describe the process and the nature of your input.
2. Did you feel you were equipped to participate adequately? Please explain your experience.
3. Were your contributions or views listening to? Please explain your reasons.
4. Were other young adults within other key populations involved in this process? If yes, did you think this was representative of the diversity of key populations?
5. Were there any risks for you or other young adults who participated in this process?
6. Based on your experience in this process what would you describe as the right space for young people to participate in to shape the future of digital rights?
7. Any lessons learned from this experience that might change how you participate in future? Please explain.

KELIN
Reclaiming Rights, Rebuilding Lives

KCAT
KENYA COMMUNITY ADVISORY TEAM

DHRP
Digital Health & Rights Project