CAPACITY BUILDING WORKSHOP ON HUMAN RIGHTS AND THE LAW IN RELATION TO HIV AND TB IN PRISON

14-16 OCTOBER, 2014 SILVER SPRINGS HOTEL
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<th>Description</th>
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<tr>
<td>ADR</td>
<td>Alternative Dispute Resolution</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immuno-Deficiency Syndrome</td>
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<td>CD4 Cells</td>
<td>Also called T-helper cells; a type of white blood cell that fights infection</td>
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<td>DPO</td>
<td>Disabled People Organization</td>
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<td>EPZ</td>
<td>Export Processing Zone</td>
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<td>FKE</td>
<td>Federation of Kenya Employers</td>
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<td>HAPCA</td>
<td>HIV &amp; AIDS Prevention and Control Act</td>
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<tr>
<td>HIV</td>
<td>Human Immuno-deficiency Virus</td>
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<td>NACC</td>
<td>National AIDS Control Council</td>
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<td>NALEAP</td>
<td>National Legal Empowerment and Awareness Programme</td>
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<td>NCPD</td>
<td>National Council of Persons with Disabilities</td>
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<td>NEPHAK</td>
<td>National Empowerment Network of People living with HIV &amp; AIDS in Kenya</td>
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<tr>
<td>OHCHR</td>
<td>United Nation Office of the High Commissioner on Human Rights</td>
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<tr>
<td>PLHIV</td>
<td>Person Living with HIV</td>
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<tr>
<td>PSV</td>
<td>Public Service Vehicle</td>
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<tr>
<td>PWD</td>
<td>Person with Disability</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>UDEK</td>
<td>United Disability Empowerment in Kenya</td>
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<tr>
<td>UNAIDS</td>
<td>United Nations Joint Programme on HIV &amp; AIDS</td>
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<td>WHO</td>
<td>World Health Organization</td>
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1.0 BACKGROUND

The Constitution of Kenya and a host of other international human rights instruments ratified by Kenya prescribe the right to the highest attainable standard of health. As a human right, the right to the highest attainable standard of health is an entitlement of all people without exception. In the context of HIV and TB, enjoyment of the right manifests in access to prevention, treatment, care and support services. However, vulnerable populations like prisoners do not usually access the right to health on an equal footing with the general populace, particularly with regard to HIV and TB prevention, treatment, care and support services. The disparities in access to HIV and TB health services thus reflect in the relatively higher vulnerability to HIV and TB among prisoners. Women prisoners are the most affected with an HIV prevalence of 19% compared to the national prevalence of 5.6% and that of women in the general populace of 6.9%. At 5.5%, male prisoners too have a higher prevalence than their counterparts in the general populace who have a prevalence of 4.4%.

The prison setting presents heightened risks for realization of the right to health given the often deplorable living conditions that characterize most of Kenya’s prisons. Prisoners have inadequate access to basic hygiene amenities. Nutrition is often poor and inadequate. This coupled with overcrowding, detention of TB drug defaulters in prisons, sexual violence among inmates and a uptake of HIV prevention services such as condoms make prison fodder for HIV and TB infections. Indeed, the findings of the Kenya AIDS Indicator Survey of 2007 and 2012 reveal no less. In 2007, the Survey established that prison inmates have among the country’s highest rate of HIV transmission, with men who have sex with men in prisons contributing to 15.2% of the new HIV infections in Kenya. Despite this state of affairs, limited research to inform evidence-based interventions for realization of the right to health in prisons have been undertaken.

Criminalization of risk factors for transmission of HIV and TB such as same-sex acts and TB drug defaulting compound the challenges faced in effecting appropriate HIV and TB responses in prisons. Because their acts are criminalized, sexual minorities, injecting drug users and TB drug defaulters often find themselves in prison for violating the law. In prison, vulnerability to HIV and TB of these already disproportionately impacted groups is escalated because a human rights based approach to HIV and TB response lacks in large part. HIV prevention and care services in prison are hardly tailored to suit the unique health needs of sexual minorities, injecting drug users and women. Consequently, the Global Commission on HIV and the Law in its report ‘Risks, Rights and Health’ has advised countries that the obligation to ensure an effective, sustainable response to HIV that is consistent with human rights requires health care to be availed in places of detention, including HIV prevention and care services, regardless of laus criminalizing same-sex acts or harm reduction. In the same vein, incarceration of TB drug defaulters in prisons ill-equipped to mitigate the public health risk they pose only amounts to yet another violation of health rights that takes place in prisons.

The need thus to engage high-ranking prison officials on laus, policies and practices that inhibit effective HIV and TB responses is deemed necessary against the backdrop that these officials, as state agents, have an obligation to respect, promote and fulfill the human right to health for persons within the prison environment, including staff.

To this end, KELIN in partnership with the Kenya Prison Service worked in close consultation with UNDP, NERPHAK, NACC, NASCOP, UNAIDS and other partners to convene a three day residential capacity building workshop for senior prison officials on Human Rights and the Law in relation to HIV and TB, with objectives to:

a) Enhance the participants’ understanding of human rights and the law impacting on HIV and TB response in prison;

b) Increase the participants’ awareness on sexual and gender-based violence, exploitation and all forms of victimization in prison especially among women;

c) Discuss the role of prison officers in upholding the rights of person living with HIV and TB with emphasis on members of key and affected populations, and women living with HIV.

The capacity building workshop targeted senior prison officers from the counties of Kilifi, Mombasa, Nairobi and Kisumu. Officers from prison facilities in Homa Bay, Nakuru and Uasin Gishu and representatives from other law enforcement agencies and key stakeholders working in prison were also invited. The workshop took place from 14 to 16 October, 2014 at the Silver Springs Hotel, Nairobi. Outcomes expected from successful utilization of the workshop’s deliberations were:

a) Increased awareness among senior prisons officers on the role of the law and of law enforcement officers in protecting the rights of people living with HIV and those infected with TB within their custody;

b) Enhanced commitment to implement measures to protect and address sexual and gender-based violence in prison and;

c) Buy in, commitment and specific proposals to advance rights based and evidence informed HIV and TB interventions taking into account specific needs of the different populations in prison and the available opportunities.

The workshop’s deliberations were:
2.0 EXECUTIVE SUMMARY

KELIN is a human rights non-governmental organization working to protect and promote HIV-related human rights in Kenya. KELIN does this by providing legal services and litigation support, training professionals and communities on human rights, engaging in advocacy campaigns that promote awareness of human rights issues, conducting research and influencing policy that promotes evidence-based change.

In line with its mandate of influencing rights-based law, policy and practice in HIV and TB, KELIN convened a three-day capacity building workshop for senior prison officials with the aim of sensitizing them on human rights-based approaches to management of HIV and TB in prisons. Discussions in the three-day workshop hinged on the disproportionately high prevalence of HIV and TB in prisons compared to the general populace. Attempts were made to diagnose the root cause of this state of affairs and an answer found in structural and resource constraints that limited the enjoyment of the right to health in prison settings.

Consequently, deliberate efforts were made to figure out ways of redressing health rights violations in prison. Guiding the possible measures of redress that participants discussed, were the findings of the report of the Global commission on HIV and the Law relevant to law enforcement and recommendations by UNODC on the comprehensive package of interventions in prisons and other closed settings. Participants discussed their role as law enforcers and of the role of the law in protecting HIV and TB-related rights in prisons. So much so that one of the recommendations agreed to by participants at the end of the workshop was to establish a Kenyan chapter of Law enforcement and HIV Networks – as part of the global movement of law enforcers committed to respect and protection of HIV rights in the course of their duties. Among many other commitments was the need to spearhead relevant research on policies and practices to identify gaps in Kenyan prisons that would guide suitable interventions for both KPS staff and prisoners in Kenya. This would help in facilitating an enabling environment that respects HIV and TB rights for more targeted and effective interventions suitable to the situation in Kenyan prisons.
3.0 INTRODUCTION

3.1 Expectations and Agenda
The workshop began with an overview of the objectives of the three-day intensive capacity building forum. Participants shared their expectations of the workshop as follows:
- To learn best practices in the management of HIV and TB.
- To understand the challenges experienced in managing HIV and TB in prisons.
- To acquire more knowledge of HIV and TB law and rights.
- To know how prison staff members are protected from HIV and TB in their work environment.
- To know how the workshop forum will benefit the prison population they serve.
- To learn challenges of PLHIV and HIV workplace policies.
- To learn HIV best practices that can be adopted in penal institutions.
- To get briefing on how partnerships with KPS in incorporating human rights based approach to management of HIV and TB are faring.
- To learn how to improve prison services as far as management of HIV and TB is concerned.
- To share HIV experiences in the Prisons Service.
- To gauge what the workshop expects prison staff to do and what they are doing in handling HIV and TB in prison.
- To understand prison staff responsibilities and rights in management of HIV and TB in prison.
- To get participants to reflect on how PLHIV are treated inside and outside prison and bridge gaps if any.
- To share lived experiences as recovering IDUs.
- To have open discussions on sexual minorities in prison.

Participants were then walked through the workshop’s agenda. The agenda was structured to first induct participants on issues of HIV and TB stigma and discrimination from a general perspective before narrowing to the prison context. The next discussions would cover sexual and gender based violence in prisons followed by a session of lived experiences of persons in the key populations who had also served prison sentences. The link between HIV, TB and human rights was scheduled to be addressed on the second day of the workshop, under sessions covering constitutional and human rights. On the second day, to identify opportunities for rights based HIV and TB interventions in prisons. On the last day of the workshop, all the deliberations would culminate in developing recommendations and action plans geared to realize outcomes expected out of the workshop.

3.2 Opening Remarks
The workshop’s deliberative sessions were preceded by opening remarks from Florence Anam on behalf of the National Empowerment Network for PLHIV in Kenya; Benjamin Njoga on behalf of the Commissioner General of Prisons; Sheila Ngatia – Assistant Country Director, UNDP Kenya; and Dr. Bathsheba Osoro on behalf of the Director of the National AIDS Control Council.

In her opening remarks, Ms. Anam observed that legal and policy interventions in Kenya have resulted to better treatment of PLHIV generally except that stigma and discrimination remain stumbling blocks to full enjoyment of rights by PLHIV. She hoped that the capacity building workshop would enhance participants’ knowledge to be able to undertake effective HIV and TB interventions that prioritize human rights in the prison setting. On his part, Mr. Njoga noted that the prison HIV workplace policy deliberately extends HIV services to both prison staff and prisoners. He reiterated that deprivation of liberty does not also deprive prisoners of their right to the highest attainable standard of health and challenged his colleagues to stem violation of health rights in prisons.

Mr. Njoga also called for research to inform evidence and rights based HIV and TB interventions suitable for the prison situation in Kenya. Adding that he believed prison officers would mount effective health interventions if equipped with the right skills and tools, he urged partnerships towards this end and underscored the need for regular monitoring and evaluation to assess progress.

Dr. Bathsheba Osoro from the National AIDS Control Council revisited HIV statistics, juxtaposing HIV prevalence rates in prison with those of the general populace. Noting that prisoners are disproportionately impacted by the HIV epidemic, she encouraged participants, as duty bearers, to learn and share best practice interventions to ameliorate the health environment in prisons and reverse the spread of HIV.

Remarks by Sheila Ngatia – Assistant Country Director, UNDP, highlighted the need for structural HIV interventions besides biomedical and behavioral interventions in prisons. Structural interventions, especially with regard to laws that obstruct effective HIV and TB responses in prisons, she observed, are necessary for challenging stigma, promoting public health, and protecting human rights. She was categorical that:
- Where the law does not stop proven HIV prevention interventions from reaching injecting drug users and prisoners, and where the law does not criminalize adult consensual sex and gender identity, HIV prevention outcomes are vastly improved.
- Where the law empowers men and women, their vulnerability to HIV and violence is decreased.
- Where the law enables men and women living with HIV to participate with dignity in daily life without fearing discrimination and possible prosecution, they are more likely to seek prevention, care, and support services.

Ms. Ngatia concluded by pledging UNDP’s continued commitment to effective HIV and TB interventions in prison settings. Underscoring that UNDP puts a high premium on such interventions, she lauded the partnership between KELIN and Kenya Prisons Service and urged participants to challenge practices that contribute to the high burden that HIV and TB place on the country’s resources.
TRAINING ON HIV, HUMAN RIGHTS AND THE LAW IN RELATION TO HIV AND TB IN PRISON
4.0 SUMMARY OF WORKSHOP SESSIONS

4.1 Burden of HIV and TB in Prison: Statistics and Updates
Facilitator: Dr. Charles Isiaho; Director of Health Services-Kenya Prisons Service
An introductory session on the general mandate of the Kenya Prisons Service linked with an exposition of the HIV and TB situation in prisons got the workshop’s deliberative sessions underway. Dr. Charles Isiaho facilitated the session. From the outset, it was evident in the mission of the Kenya Prison Service: “to contain offenders in humane safe condition in order to facilitate a responsive administration of justice, rehabilitation, social reintegration and community protection,” that prisoners are entitled to protection of, among other things, their health. This premise was bolstered by reference to constitutional and legislative frameworks from which Kenya prisons derive mandate. The facilitator referred to the Prisons Act, the Borstal Institutions Act and the Constitution, emphasizing that the latter together with the United Nations Standard Minimum Rules for Treatment of Prisoners require that prisoners be treated with dignity. This, he said, calls for respect of prisoners’ health among other rights. The facilitator then expounded on the prisons’ staffing levels with particular emphasis on health care personnel. The inadequate number of health personnel working with prisons, in part contributes to the challenges in management of prisoners’ health rights. Participants also learnt that there is usually a high turnover in the prison population which makes management particularly of HIV and TB difficult in the absence of follow up services when prisoners are set free. While the prison population in Kenya is estimated to be 49,364 male prisoners and 3,090 female prisoners, turnover in the number of inmates that enter and leave prison annually is estimated to be at 300,000 people. Adding to the challenges faced in provision of adequate health services in prisons is also that the Prisons Department has for a long time been under-funded by the national government, leading to poor physical and living conditions that predispose both inmates and prison staff to illnesses that are otherwise preventable, including TB and other HIV-related opportunistic infections.

A further challenge in addressing prison health is presented in the confusion following devolution of the function of basic health services to county governments whereas prison services remain the function of the national government. This, the facilitator noted, has resulted in some county governments abdicating responsibility for providing health services to prisons, citing that the responsibility falls to the national government. To unlock the stalemate, the facilitator recommended the need to lobby county governments to embrace provision of health services to prisons within their jurisdictions as has been done by the County Government of Kisumu. He also called for recruitment of more skilled health personnel in order to minimize the amount of time taken before a sick prisoner is attended to. Prison health facilities, he added, require urgent upgrading to be able to offer more health services especially because the prison population includes the elderly, the disabled and the terminally ill whose health needs are specialized. Currently, there are only 5 health centers and 66 dispensaries in prisons. Touching on factors affecting disease burden in prisons such as accommodation, clothing, access to basic hygiene amenities, nutrition, vector control and health care services; the facilitator noted that if these are improved, the risk of prisons acting as reservoirs for diseases, especially HIV and TB, will be minimized. He concluded by revisiting the disproportionate burden of HIV and TB in prisons compared to that of the general populace. Both female and male prisoners have a combined HIV prevalence rate of 8.2% while the national prevalence stands at 5.6%. Prevalence of TB in the general populace is 298:100,000 (which approximately translates to 30:10,000) whereas that of the prison population is 76:10,000. Despite this high burden of HIV and TB, the facilitator acknowledged that prison health services are often constrained by shortage of medical commodities; loss of documentation of would-be prisoners who require HIV and TB medication in the shutting between police custody and prison; criminal minds in prisons who perpetuate sexual violence; and prison congestion.

Plenary
- Reacting to the inadequacy of health services provided in prisons, a participant wondered what a prison officer without experience of handling TB issues is supposed to do with incarcerated TB drug defaulters. It was observed that the use of custodial sentences for health related offences needed to be reviewed.
- A participant who seemed to think that basic amenities and living conditions in prisons should first be improved before advocating for prisoners’ HIV related rights was met with the question: are some rights more important than others? One more participant argued that prisoners asked to prioritize their needs ranked food and basic amenities higher than HIV prevention services. This argument exposed the lack of appreciation for indivisibility and interdependence of rights that often fuels violations.
- More views were aired to the effect that condom programming and protection of rights of sexual minorities in prisons, as HIV interventions, are a result of external clamor and as such local research needs to be undertaken to establish the effectiveness of these interventions in curbing the spread of HIV in prisons within Kenya.
- A recommendation by the facilitator proposing mandatory HIV testing for prisoners as an intervention measure for curbing transmission of HIV elicited mixed reactions. The objectivity in mandatory testing was deliberated with arguments that it should be purely for treatment purposes and others opining that if mandatory testing is proposed then both preventive and treatment services would have to be availed. Even so mandatory testing could not guarantee sustainable adherence to treatment nor prevention.
- A participant who had misconstrued provisions of the Prisons Act on medical examination as giving leeway for mandatory HIV testing of prisoners learnt that the law regulating HIV testing is the HIV & AIDS Prevention and Control Act and its provisions prohibited mandatory testing of HIV except under very specific circumstances to be discussed in a subsequent session.
- Arguments were raised that if the purpose for the testing is skewed in favour of treatment services, it would amount to an insinuation that the rights of prisoners living with HIV are more important than those of prisoners living without if mandatory testing does not yield the same fervor for preventive services.
In Kenya, discrimination is widely discernible in:

- A particular group.
- Him being treated unfairly or unjustly on the basis of belonging to when a distinction is made against a person that results into her/his discrimination. She explained that discrimination occurs when a distinction is made against a person that results into her/him being treated unfairly or unjustly on the basis of belonging to a particular group.

In Kenya, discrimination is widely discernible in:

- Punitive laws against PLHIV and TB patients.
- Denying PLHIV and TB patients information/services in public facilities.
- Inadequate involvement of PLHIV/ those affected by TB in decision making affecting their health and social wellbeing because of a perceived lack of value of these persons.
- Inadequate enabling environment for access to treatment and prevention interventions.
- The impact of the foregoing manifestations of stigma and discrimination to health care has been:
  - Irregular care clinic attendance by PLHIV and TB patients.
  - Poor TB screening because people do not want to be screened unwillingly as this may lead to being discriminated if the test results are positive.
  - Low HIV testing rates for the same reasons as above.
  - Poor adherence to treatment.
  - Death as a result of preventable causes, leading to proliferation of orphan and vulnerable children.
  - Burden to the health care system due to morbidity that could have otherwise been prevented.
  - By sharing personal experiences as a young woman living with HIV, the facilitator was able to present the lived experience and challenges of those living with and affected by HIV. The facilitator concluded by proposing steps that participants can take to address stigma and discrimination in their own prison setting including:
    - Changing their language - use language that is respectful to PLHIV and TB patients.
    - Awareness creation to educate and impart knowledge on HIV and TB in order to diffuse misconceptions that fuel stigma.
    - Talking openly about HIV and TB.
    - Supporting access to quality prevention, treatment, care and support services and advocating for laws and policies that provide for an enabling environment.
    - Encouraging use of lived experience to influence behavior change and reduce stigma.

Facilitator: Florence Anam; Communications Officer-NEPHAK
The objective of this session was to familiarize participants with the meaning of stigma and its manifestations and how these impact on effective HIV and TB responses. The facilitator, Ms. Florence Anam, began by soliciting participants’ own understanding of the term ‘stigma.’ They responded by associating stigma with unfair treatment, fear mongering and disrespectfulness. The facilitator concurred and added that stigma is a social construct. There are two kinds of stigma: external stigma emanating from society and self-stigma emanating from within. She informed participants that external stigma often manifests in discrimination, which in turn leads to violation of the rights of the stigmatized person. Self-stigma on the other hand manifests mainly in low self-esteem, shame and low confidence.

The facilitator gave examples of stigma initially witnessed by PLHIV when HIV was stereotypically associated with immorality. She attempted to diagnose the causes of such stigma and arrived at fear of death as the main cause. HIV and TB originally presented as diseases that kill and as people had little knowledge of the epidemiology of the two, they reacted by shunning infected persons. At this point, the facilitator underscored the importance of awareness creation in dispelling unfounded fears which perpetuate stigma. She informed participants that stigma drives people away from seeking preventive, treatment, care and support services. Consequently, stigma fuels the spread of HIV and TB as intervention measures are avoided. Enacted external stigma, she said, is discrimination. She explained that discrimination occurs when a distinction is made against a person that results into her/him being treated unfairly or unjustly on the basis of belonging to a particular group.

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- Denying PLHIV and TB patients information/services in public facilities.

4.2 Impact of Stigma and Discrimination on Uptake and Retention to Care for HIV and TB Interventions

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- Punitive laws against PLHIV and TB patients.
- Denying PLHIV and TB patients information/services in public facilities.
A section of participants observed that the situation was worse for staff uptake of HIV services because most interventions in prison focused on the prisoners to the exclusion of staff;

There was an acknowledgement that though the prison environment may not be as conducive for staff uptake of HIV services as should be, there have been improvements as indicated by increasing number of staff that are coming out openly to declare that they are living positively. This, it was observed, would not be possible if stigma and discrimination levels were high;

Some participants opined that the existence of a peer support group at the workplace, facilitated an environment conducive for uptake of voluntary HIV services by staff;

One participant noted that the HIV support group at her prison prefers to meet outside the workplace environment, which she felt was indicative of vestiges of stigma and discrimination. It was ascertained that support groups should not only target PLHIV but also provide support for those affected so as to alleviate the fear of inferences that may be drawn about HIV status of group members;

A participant who sits in the disciplinary board of the Prisons Department felt that the prison environment is not conducive for staff uptake of HIV services because some of the cases the board deals with involve absenteeism from work by officers who need HIV support but do not disclose their status in order to be accorded reasonable accommodation. These sentiments were echoed by more participants who added that there was need to create a much more conducive environment especially for younger prison officers who exhibit less willingness to seek HIV support;

Also revealed in the plenary discussions was that some prisons had a more conducive environment for staff uptake of HIV services than others. In order to bridge this gap, it was suggested that the AIDS Control Unit of the Kenya Prisons Service should put in place standardized mechanisms from induction and periodic processes for sensitization on HIV related support for all staff to encourage uptake of HIV services across all prisons.

4.3 Addressing Sexual and Gender Based Violence affecting Women and all Forms of Victimization in Prison

Facilitator: Carol Ajema; Gender Programme Officer-Liverpool VCT

The objective of this session was to get participants to view HIV risk factors and possible interventions from the perspective of gender-specific needs. Carol Ajema from LVCT facilitated the session. As a risk factor for transmission of HIV, she pointed out that sexual and gender based violence is prevalent in Kenya with statistics indicating that up to 45% of women in the age brackets of 15 – 49 years have experienced some form of gender based violence. The higher risk that women face of sexual and gender based violence perhaps also explains in part the higher HIV prevalence rates among women. Prisons are no exception.

The facilitator particularly linked SGBV to transmission of HIV as victims of the violence are usually in no position to negotiate for safer sex practices. Noteworthy also was the facilitator’s demonstration of how SGBV can occur in subtle circumstances that may not necessarily reveal absence of consent but which certainly do not amount to consent for a sexual act. These circumstances were typified by case scenarios where the victims hold either of the following sentiments:

“I did not say no but I did not mean yes.”
“I moved away from you but you moved closer.”

“I tried to push you away but you kept going.”
“I said I was tired. You ignored me.”

As a way of mitigating the impact of SGBV on victims, including victims in prison, the facilitator recommended availability of the following services:

- Psychosocial support and counseling.
- HIV testing and prevention services.
- STI screening and treatment services.
- Pregnancy prevention and management services.
- Emergency contraceptive services.
- Hepatitis B vaccination.
- Collection of forensic evidence to help bring perpetrators to justice.
- Legal aid for victims to help them access justice.
She urged participants, as duty bearers for fulfillment of prisoners’ right to health, to fully avail these services in prisons and where they cannot be immediately provided, to establish referral mechanisms through which prisoners, especially female prisoners, can access the services on equal footing with the general populace.

Plenary

– Participants interrogated the research findings presented and requested for the report by LVCT to be shared with them for closer review on the findings and recommendations.

– A participant noted that comprehensive SGBV services are an essential package for protection of vulnerable people’s health rights especially because of high turnover in the numbers of incarcerated people. People get into and leave prison after a short time, necessitating such interventions in case they are predisposed to violence by the fact of their increased vulnerability as newcomers.

– Triza Nafula of The Omari Project shared the above interventions in their intervention package. The next inclusion in their intervention package will be linking recovering IDUs with their families because some of them get isolated from family due to drug addiction and frequent arrests. The Omari Project provides interventions for injecting drug users. In prison, they sit on the discharge board where their interventions include decongestion of prisons by channeling imprisoned IDUs to health facilities. They also sit in the Court Users Committee to influence diversion programmes and use of non-custodial sentences for IDUs so that these are channelled to health facilities to be assisted with their addiction instead of being subjected to imprisonment. Among the services they offer to IDUs are addiction counselling, awareness creation on the effects of drugs and harm reduction services. They have now broadened their range of interventions to include HIV testing and counselling, hepatitis and TB screening, and acupuncture for stress management. They also link recovering IDUs with their families because some of them get isolated from family due to drug addiction and frequent arrests. The next inclusion in their intervention package will be linking recovering addicts with livelihood opportunities.

– Some participants were of the view that there may be mechanisms for addressing SGBV in prison rules and regulations but these are inadequately implemented in practice.

– A recommendation was made for research to assess the existing mechanisms to address SGBV in prisons particularly for staff and their families. This would provide useful information on the manifestation of SGBV and whether the available mechanisms were effectively responding and addressing the needs.

4.4 Moderated Panel Discussions of Lived Experiences of Former Prisoners on Issues of Key Populations

The objective of this session was to help participants understand violation of HIV and TB rights in prison from the standpoint of imprisoned injecting drug users, PLHIVs, TB patients, sex workers as part of the vulnerable groups in prison. Former prisoners who belong to these groups shared their lived experiences.

Amina, recovering injecting drug user, PLHIV

Amina was first imprisoned in 1999 and has since become a jailbird. Her crimes have all been related to heroin addiction. At the time of her first imprisonment in the year 1999, she says prison health services and living conditions were deplorable. Once she went to prison while pregnant. She did not realize it until she missed her periods. Then she asked to be taken to hospital because the prison dispensary did not offer antenatal services. She did not receive any PMTCT services during the time of her incarceration and consequently the baby she delivered acquired HIV and died of related infections. She urges prison staff not to stigmatize PLHIV. Her experience in prison has been that medication for PLHIV prisoners is administered in the open; so that the HIV status of those who go to receive the medication is revealed to all and sundry.

Jamal, recovering injecting Drug User

He too is a former inmate because of heroin addiction related crimes. Since his first imprisonment in 1987, he has returned to prison no less than 14 times. His last imprisonment was in 2011 and he acknowledges that changes have since been made to improve the welfare of prisoners. Injecting drug users are beginning to be perceived as victims and not villains. His concern though is that addicted injecting drug users will do anything to access their drugs in prison, even if it means risky behavior that exposes them to HIV and hepatitis infection. He sighted that drug use within prisons was rampant and exposed convicted drug users to concoctions that are more difficult to quit. He asks that they be provided with harm reduction services to protect their health. He also recommended the use of non-custodial sentences to facilitate rehabilitation.

Triza Nafula, Programmes Officer, The Omari Project

The Omari Project provides interventions for injecting drug users. In prison, they sit on the discharge board where their interventions include decongestion of prisons by channeling imprisoned IDUs to health facilities. They also sit in the Court Users Committee to influence diversion programmes and use of non-custodial sentences for IDUs so that these are channelled to health facilities to be assisted with their addiction instead of being subjected to imprisonment. Among the services they offer to IDUs are addiction counselling, awareness creation on the effects of drugs and harm reduction services. They have now broadened their range of interventions to include HIV testing and counselling, hepatitis and TB screening, and acupuncture for stress management. They also link recovering IDUs with their families because some of them get isolated from family due to drug addiction and frequent arrests. The next inclusion in their intervention package will be linking recovering addicts with livelihood opportunities.

Triza Nafula of The Omari Project shared the above interventions in order to expose participants to various rights-based interventions that can be undertaken for recovering IDUs. These interventions require prisons to partner with organizations such as The Omari Project to ensure sustainability in reforming IDUs while curbing the spread of HIV, TB and Hepatitis among this particularly vulnerable group.

Mugure, sex worker, mother, PLHIV

There was a time she was arrested with her workmates while plying their trade as sex workers and ended up at a Women’s Prison. Before imprisonment, she remembers going to remand offices where a remand officer asked them to change into white clothing, referring to them as “wako wapi hao malaya wenye walishikwa wakiuwa uchi?” She needed her HIV medication then but could not approach the hostile officer who was already referring to them in derogatory language. She waited for another officer to arrive. Hoping this one would be a little respectful. To her surprise and dismay, the officer brushed her off and told her she would be attended to the next day. So she skipped her HIV medication for a day.
The next day did not bring better tidings. When she told yet another officer of her need for medication, the officer retorted “kama ulijua unahitaji dawa, haungekuwa kuwa barabara.” It soon became commonplace for her pleas for medication to attract scorn from one officer to another. Some even thought that the pleas were a ploy to attract sympathy and be exempted from manual work that had become part of their routine in detention. The crux of Mugure’s story is that she went without HIV medication for three weeks while in detention. She felt humiliated each time she asked for medication and got taunted for it.

Phelistar, Activist for Sex Workers’ Rights-KESWA
She works with the Kenya Sex Workers Alliance and says the alliance was formed to counter discrimination and violation of sex workers’ rights. The nature of sex work is such that it exposes them to violence from clients and if an enabling environment is not created for them to report perpetrators and practice safer sex, their vulnerability to HIV infection is amplified. Phelistar deplores police swoops in which sex workers get arrested and the condoms in their possession used as exhibits in court. The swoops, she says, are counterproductive for efforts to contain the spread of HIV. If condoms are used as evidence for a criminal charge, sex workers are discouraged from possessing them and practicing safer sex. She calls for law enforcers to be mindful of the welfare of sex workers, even in prison. Sex workers are often the target for violence from fellow inmates because their means of livelihood are stigmatized. She condemned laws in Kenya that criminalized sex prostitution and questioned the objective that informs imprisonment of sex workers blaming these for ill-treatment of sex workers. She explained that her organization strives to ensure that before they are able to secure legal representation for arrested sex workers, they attend to their immediate needs such as availing their TB or HIV medication and safety of unattended children.

“Sadly, due to the nature of our work, police and prison are a regular occurrence. All I request is for sex workers be treated with dignity while in custody, remand or imprisonment and be facilitated with timely attention to their medical needs. This is for their own good health but will also benefit officers and other prisoners in contact with them,” she observed.

1 Kisuahili for “Where are the prostitutes that were arrested naked?”
2 You would not have been on the road soliciting for clients if you really knew that you needed medication.

Daniel, TB drug defaulter
Daniel was sentenced to eight months’ imprisonment for defaulting on his TB medication. The rationale for his imprisonment was that he posed a health risk to the public and needed to be confined and put on compulsory treatment to minimize the risk. In prison, he slept in a congested room full of lice, despite his illness and his nutritional needs remained unaddressed. He regrets that had he been properly counseled on treatment adherence and the social and legal consequences of defaulting on TB medication, he would have endeavored to adhere to treatment and would not have ended up in prison. He shared that upon securing his release, KELIN included him in a community training on rights based TB management for stakeholders. He has since completed his treatment. A Constitutional petition is pending in court on the use of prisons as the contemplated place of confinement for purposes of enforcing Section 27 of the Public Health Act.

1 Daniel was imprisoned on grounds of section 27 of the Public Health Act and his case is sub judice with regard to an application made to court to seek determination on the propriety of prisons as the choice place for confinement of TB drug defaulters who pose a public health risk. For more visit https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=weblinks&cd=1&cad=rja&uact=8&ved=0CB0QFjAA&url=https%3A%2F%2Fkelinkeny.org%2Fwp-content%2Fuploads%2F2010%2F01%2FAdvisory-Note-on-Arrest-of-TB-Patients-in-Kapsabet.pdf&ei=RfUl5L28JbpOS4yNgI&usg=AFQjCNhCoBFuJufh9ZdNaQxM-j4uA&sig2=BquZ0OQiUL8muUOCCgJ9

Plenary
– Participants reacted to cases of imprisonment of TB drug defaulters saying that even if prisons had isolation rooms, the TB patients would still need to be attended to by prison officers to whom they would pose a health risk. Prisons are understaffed in terms of health care workers and not all staff are trained to manage TB. Overcrowding in prison poses a much greater risk of the spread of TB and management of patient poses a challenge e.g. Dietary needs cannot not be met. There was consensus thus that prison is not the right place for confinement of TB drug defaulters that pose a health risk to the public.

– Participants felt that Daniel’s case elicited many concerns other than non-adherence to TB medication. Participants wondered whether Daniel’s infectiousness was determined at trial to determine if he posed a health risk at the time of his arrest, and whether care was provided to all who were in contact with him following his arrest e.g. while police custody in cells where ventilation is inadequate. They thus called for better methods of handling TB drug defaulters in totality.

– There was also concern from participants that when TB drug defaulters are imprisoned pursuant to court orders, prison officers can do little else as they would be held in

Anne Ronu, PLHIV–NEPHAK Representative, Nandi County
She advocates for respect of the rights of PLHIV and TB patients. KELIN and NEPHAK learned of the case of Daniel and three others, through her. She says that even though Daniel had been incarcerated on the ground that he posed a health risk to the public, they did not detain him in isolation which negates the objective of protecting the public as he posed the same risk to inmates and prison staff. After Daniel’s incarceration, there was increased unfooted fear of TB in the community, leading to victimization of TB patients and widespread fear among PLHIV communities. KELIN and NEPHAK however organized a sensitization forum for the community that brought together duty bearers and patient communities to discuss the root causes of TB treatment default. Collaborative efforts have resulted in better coordination and support for TB patients in the county to encourage voluntary uptake and completion of treatment. A functioning TB clinic has also been constructed and is easily accessible and provides better support services.
contempt of court if they do not enforce the orders even where they may not have adequate isolation facilities. In view of this, participants asked that sensitization on rights based approach for handling of TB drug defaulters should also involve other actors in the criminal justice system, including magistrates and the police.

A participant in favour of confinement of TB drug defaulters posed the question that what message would be passed to the defaulters if they knew that legal proceedings could be undertaken to spare them imprisonment? Non-custodial options were suggested such as house arrest or isolation in medical facility.

Also eliciting reactions of participants was the issue of incarceration of sex workers. A participant felt that if the object of prison is to serve as correctional facilities, prison is not the right place for sex workers who like what they do, adding that a person who enjoys their work cannot be rehabilitated out of it. They questioned the role of prison in relation to sex workers.

A moment of reflection dawned on participants and they reminisced that they were not prepared to deal with TB patients and sex workers at the Prisons College. “We are taught to deal with hard core criminals. I would not know how to handle the issues of sex work and drug users who need other support perhaps outside prison”

Whilst admitting some of the challenges identified by the panelists, a senior officer from the prisons service informed participants that KPS was undertaking reforms to improve management, service delivery, and prison conditions in Kenya. Participants felt the session presented the realities in prison and committed to addressing some of the concerns shared in their various facilities.

4.5 Overview of Human Rights and How the Constitution of Kenya Advances the Rights of PLHIV and TB Patients

Facilitator: Commissioner Catherine Mumma; Commission on the Implementation of the Constitution

This session was designed to introduce participants to human rights in general before narrowing down to constitutional protection of the rights of the rights of PLHIV and TB patients. Participants were informed that human rights are inherent entitlements of all human beings, including prisoners. They were also informed that human rights are interrelated and interdependent. The facilitator, Commissioner Catherine Mumma, elaborated that interrelatedness of rights precludes the temptation to create a hierarchy that ranks some rights as more important than others. All rights are equally important, as exemplified by denial of the right to health while one is given the right to live. Life without health is agonizing. Interdependence of rights, she explained, means that a right may be dependent on realization of another for it to be also realized fully. To illustrate, she gave the example of the right to health and its interdependence on the right to water, food, sanitation and information.

The facilitator also explained that at the center of rights is the right to participation and inclusion which requires governance to take into account the views of the governed. The concept of duty bearers was introduced to participants. They learned that the State is the primary duty bearer for fulfillment of rights, particularly prisoners’ right to health. As state agents, participants learnt that it was their responsibility as well to promote and uphold the rights of prisoners, including those in the context of HIV and TB.

Participants were also informed of the secondary responsibility of private persons to respect the rights of others. It is criminalization of violation of other people’s rights that leads to imprisonment of offenders. However, the purpose of imprisonment is rehabilitation of the offender, and as such, incarcerated offenders do not lose their human rights except deprivation of liberty. This, the facilitator explained, entails prisoners to be accorded the right to health care on equal footing with everyone else in society.

The facilitator then reinforced the link between human rights and HIV by stating that lack of respect for human rights fuels the spread and exacerbates the impact of the epidemic. Perhaps this explains why HIV prevalence rates are disproportionately high in prison settings where the right to health for prisoners is not fulfilled in the same measure as it is for the general public. Participants were urged to understand their responsibilities towards fulfillment of the rights of prisoners in order to effectively undertake interventions that will reverse vulnerability to HIV and TB in prisons. They were especially urged to conform to Articles 24, 61 and 27(2) of the Constitution while discharging their responsibilities. The facilitator concluded by reminding participants that the Constitution accords everyone the right to health indiscriminately and Articles 25 and 51 are unequivocal that detained persons retain fundamental rights such as the right to health.

Plenary

- Reflecting on their obligations to protect the rights of prisoners, participants asked the facilitator whether prisoners’ right to health fell within the mandate of national government or county governments. Response given was that county governments are duty bearers for fulfillment of the function of basic health services, meaning that all health facilities from level five hospitals going downwards fall within the ambit of counties. However, as prison services are generally the mandate of national government, need for clear policy guidelines to ameliorate access to health services by prisoners was deemed prudent.

- Questions were also raised as to where prison staff and prisoners who get infected with TB as a result of incarceration of TB drug defaulters can lodge their complaints. They were advised to report the same to national human rights institutions and explore filing a public interest case to resolve the issue for the benefit of all.
Another question raised was as to whether there were mechanisms to protect HIV negative prisoners from contracting HIV against the backdrop of sexual acts taking place in prisons. The facilitator responded that it is the same HIV prevention mechanisms available in the general populace that should be availed to prisoners, including provision of condoms.

A participant felt that prisoners’ right to health is violated when there are no drugs in public hospitals and inmates have no money to purchase drugs for themselves. He wanted to know what could be done to stop this kind of violation. This shortage, participants added, means that PLHIV and TB prisoners sometimes do not get their medication in time and in the worst case scenario, they miss medication altogether.

Also reflecting on the obligations of prison staff to prisoners as far as health rights are concerned, a participant felt time was ripe for prison officers to be fully empowered to handle HIV and TB issues in prisons from a rights based approach.

A section of participants called for involvement of prison officers as stakeholders in the formulation and review of national HIV and TB policies as the prison setting presented unique health challenges.

There appeared to be some kind of disconnect from the reality on the ground for a participant who denied the existence of IDUs and men having with men in prison. The participant also denied the existence of multi-drug resistant TB in prisons before learning of the lived experience of Daniel, a participant who had been invited to share the story of his incarceration as an MDR TB patient.

Some participants complained that civil society organizations have in the past assisted prisons to deal with cases of TB but the partnerships have been sporadic and unsustainable. They called for more sustainable partnerships between prisons and civil society organizations in infusing rights based approaches in management of HIV and TB in prisons.

A participant framed the obligation of his colleagues to uphold health rights of prisoners differently. He urged them, as law enforcers, to remember that besides security their responsibilities also include safety which means that they owe the public a duty of protection against the spread of HIV and TB. He added that the duty of protection can only be effectively fulfilled if prisoners are also protected from HIV and TB, otherwise they would be reservoirs for transmission of the illnesses to the community upon release.

Yet another participant admitted that there are no prison specific policies on TB. The prisons currently use guidelines from the Ministry of Health prescribed for the general population which are not specifically tailored to suit their unique context.

### 4.6 Legal and Ethical Considerations that Impact on the HIV and TB Response in Prisons

**Facilitator:** Ambrose Rachier; Chairperson-KELIN

The session began with a statement from UNAIDS on HIV in prisons: “by entering prisons, prisoners are condemned to imprisonment for their crimes; they should not be condemned to HIV and AIDS. There is no doubt that governments have a moral and legal responsibility to prevent the spread of HIV among prisoners and prison staff and to care for those infected. They also have a responsibility to prevent the spread of HIV among communities. Prisoners are the community. They come from the community, they return to it. Protection of prisoners is protection of our communities.”

Through the statement, Mr. Ambrose Rachier who facilitated the session once again drew participants to their responsibilities in upholding health rights in prisons. The facilitator added that prisoners require special protection of their health rights because of their vulnerability by reason of incarceration. He informed participants of Article 21 (3) of the Constitution which imposes on the State the duty to protect vulnerable persons. Also adding voice to the reality of same-sex acts in prisons, the facilitator shared that he visited Kodiaga, King’ong’o and Kamiti prisons in 1999 and prisoners there told him that they were married to each other – alluding to occurrence of same-sex relations. Without availng such prisoners HIV prevention services, the facilitator noted that they were bound to infect or get infected with HIV.

The facilitator also reiterated the link between HIV and human rights, saying that human rights questions in HIV include medical issues (rights to prevention, treatment, care and support services) and socio-cultural issues (stigma, discrimination, the debate on whether HIV testing should be mandatory or voluntary, and confidentiality of test results). That HIV is highly stigmatized, he noted, is exemplified in obituaries and eulogies that never associate deceased persons with HIV, even after 30 years since the emergence of the epidemic. He explained that medical and socio-cultural issues in HIV impact on intervention measures and people’s uptake of the interventions hence the need for legislation to create an HIV responsive environment. Participants learnt that the legislation on HIV governs the following main legal and ethical issues:

1. Consent
2. Testing
3. Privacy and Confidentiality
4. Stigma and Discrimination
5. The place of criminal law in HIV
On legal provisions on consent before being subjected to HIV testing, participants learnt that there is an exception that erodes requirement of consent where one is charged with a sexual offence. The facilitator also called on participants to be alive to their legal obligation to mount effective HIV and TB responses as besides the Constitution, they are charged by Section 30 of the Prisons Act with a duty of care over prisoners. Section 39 of the Prisons Act further mandates prison officers to take sick prisoners to hospital where the prison environment is not suitable accommodation for the ill prisoner. Section 56 of the Act perhaps provides a solution for incarceration of TB drug defaulters in prisons by providing that: “whenever it appears to the officer in charge that it is desirable for the good order and discipline of the prison for a prisoner to be segregated and not to work nor be associated with other prisoners, it shall be lawful for such officer to order the segregation of such prisoner for such period as may be considered necessary.”

The facilitator concluded with the following recommendations to participants in effecting HIV and TB responses:

- Ensure surveillance and other prevention measures that arrest the spread of HIV and TB in prisons
- Practice higher standards of observation and enforcement of human rights in prison

### Plenary

- A section of participants reacted to the issue of condom programming in prisons, saying that as state officers they are duty bearers tasked with the safe custody of prisoners and as such were unable to undertake any actions that would be construed as condoning criminal activity.
- However, dissenting sentiments argued that whether availability of condoms in prison does not negate the crime of same sex acts or having canal knowledge against the order of nature any more or less of an offence. What should really matter is the overriding objective to curb the spread of HIV. All HIV prevention commodities should be availed in prison to realize this objective of reducing new infections where inmates are caught committing an offence; appropriate action should be taken.
- An observation was made that condom programming for prisons is not the same as providing condoms to prisoners! Condoms can be placed strategically in places like toilets where whoever needs them can access them.
- Participants agreed that the issue of condom programming is a grey area that requires open and inclusive discussions by all stakeholders. Research to inform piloting of HIV prevention interventions would be key before mass roll out in Kenyan prisons.
- Discussions on criminalization of deliberate transmission of HIV followed. A participant urged quick repeal of Section 24 of the HIV and AIDS Prevention and Control Act to do away with the criminalization. It was also argued that mandatory HIV testing of suspects of sexual offences unnecessarily infringes on the suspect’s rights where the case ends up in acquittal. It was proposed that proof of the sexual offence should precede mandatory testing so that HIV rights are not unnecessarily infringed.
- A participant feared that prisoners are now very aware of their rights and junior prison officers will be caught in the crossfire as prisoners become litigious when their rights are violated by officers who do not know any better. More sensitization and continuous engagements on rights and responsibilities was recommended for prisons officers as well.

### 4.7 Opportunities for Rights Based HIV and TB Interventions in Prisons and Closed Settings

**Facilitator: Dr. Saade Abdallah-UNODC**

This objective of this session was to move discussions on HIV and TB rights in prisons forward by getting participants to begin to reflect on possible interventions that can be undertaken to protect the health rights of prisoners. Dr. Saade Abdallah facilitated the session. She underscored that prison congestion is part of the reason why health services for prisoners are constrained yet so many of those incarcerated are petty offenders for whom non-custodial sentences could suffice. She emphasized that HIV and TB prison interventions should be guided by the following principles:

- Good prison health is good public health
- Good prisoner health is good custodial management
- Respect for human rights and international law
- Adherence to international standards and health guidelines
- Equivalence in prison health care to what is available in the community
- Evidence-based interventions to inform development of prison policy, legislation and programmes
- A holistic approach to health management
- Addressing vulnerability, stigma and discrimination
- Reducing prison populations and congestion (e.g., decrease number in remand via alternative sentencing and court diversion for drug users to health and social services

The facilitator explained that good prison health is good public health because the majority of people in prisons eventually return to their communities and if they are unhealthy, they may infect the communities. She also elaborated that respect for human rights demands that prisoners should be accorded health rights equivalent to those that have been accorded to the general population. To this end, she proposed 15 key interventions heralded as a comprehensive package for HIV and TB response in prisons. The package was developed by UNODC in consultation with the Kenya Prisons Service. It prescribes the following interventions:

- Information, education and communication
- HIV testing and counselling
- Treatment, care and support
- Prevention, diagnosis and treatment of tuberculosis
- Prevention of mother-to-child transmission of HIV
- Condoms provision
- Prevention and treatment of sexually transmitted infections
- Prevention of sexual violence
- Drug dependence treatment including Opioid Substitution Therapy
- Needle and syringe programmes
- Vaccination, diagnosis and treatment of viral hepatitis
- Post-exposure prophylaxis
- Prevention of transmission through medical or dental services
- Prevention of transmission through tattooing, piercing and other forms of skin penetration
- Protecting staff from occupational hazards

Plenary

- It came out from participants that of the 15 interventions proposed by the UNODC comprehensive package, 13 had been adopted for implementation by the Kenya Prisons Service. Condom programming and clean needles for IDUs were still contentious and as such could not be adopted.
- Participants requested for wide dissemination of the comprehensive package to facilitate accelerated implementation. The ACU was challenged to assess the level of compliance in implementation of the proposed package for prisoners.
- Participants learnt that the Ministry of Health has approved the use of methadone as opioid substitution therapy and a pilot project utilizing methadone would soon be launched by UNODC and stakeholders in Mathari Hospital, Kisauni Health Centre, Malindi Hospital and Coast General Hospital. The project will first target IDUs in the community. It is hoped that its access would help sway policy makers in favour of similar interventions in prisons. The facilitator explained that methadone is sustainable for rehabilitation of IDUs as chances of relapse to heroin use are low where methadone is utilized.
- A participant sought to know if methadone is an intervention for drug users addicted to heroin only and if it were he asked of the interventions that can be adopted for persons addicted on other drugs. The facilitator responded that heroin addiction was being prioritized because HIV prevalence is higher among heroin addicts than other drug addicts.
- Participants raised concern about the rampant cases of alcohol abuse among prisons staff. They recommended that specific intervention be designed to support staff and their families battling with alcohol abuse as this affects their performance at work and social life.
- Following a county dialogue forum in Kilifi there have been more efforts in trying to address the needs of drug addicts. They were informed that there is a Bill before the County Assembly of Kilifi seeking to upgrade the county’s rehabilitation center. University of Maryland prison programme is also planning prevention and policy interventions.
- For a moment participants were immersed in discussions on the need to dismantle drug cartels as a means of solving the problem of drug addiction. They were convinced however that it would be much easier to end the addiction problem by killing demand using opioid substitution therapy than to wage war with cartels.
- Best practice in tackling drug addiction in Kamiti prison was shared with participants. Realizing the gravity of the problem, an initiative addressing issues of drug addiction among prisoners dubbed “Drugs ni Noma” has been formed.

4.8 Group Session: Challenges and Possible Interventions

After the session on opportunities for rights based HIV and TB interventions in prisons, participants were given an opportunity to brainstorm in groups and identify possible interventions that they felt need to be undertaken to enhance realization of health rights in prisons. They were also required to identify possible partners that could help implement the interventions. Their responses are captured below.

GROUP 1: The Role of Prison Officers in Enforcing Rights of PLHIV and TB Patients

This group was asked to identify:

a) Common violations of human rights in prisons
b) Challenges in addressing the violations
c) Possible interventions that can be undertaken to circumvent the challenges
d) Possible stakeholders and partners in implementing the interventions

<table>
<thead>
<tr>
<th>Violation</th>
<th>Challenges</th>
<th>Possible Intervention</th>
<th>By Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate confidentiality</td>
<td>Inadequate information on HIV, insensitive handling of PLHIV</td>
<td>Train personnel, orientation of prisoners upon admission</td>
<td>OIC, KPS ACU, KELIN, Medical staff</td>
</tr>
<tr>
<td>Insufficient diet</td>
<td>Inadequate funds for special diet, fluctuating numbers of prisoners, impeding proper planning, lack of disclosure of HIV status so as to be given proper nutrition</td>
<td>Supplementary diet, change dietary scale, kitchen gardening for support groups</td>
<td>KPS Partners, Government of Kenya, County governments, Ministry of Health, OIC</td>
</tr>
<tr>
<td>Lack of immediate access to medical personnel</td>
<td>Insufficient medical personnel, non-disclosure of health needs, inadequate trained medical personnel</td>
<td>Recruitment of more technical staff/placement of medical personnel at the point of admission to prison</td>
<td>GoK, Partners (NGOs), OICs</td>
</tr>
<tr>
<td>Stigma and discrimination</td>
<td>Inadequate counsellors, attitude and culture, fatigue</td>
<td>Train counsellors, sensitization of staff, increase numbers of staff</td>
<td>GoK, KELIN; NGOs, OICs, ACU</td>
</tr>
</tbody>
</table>
GROUP 2: Addressing Sexual and Gender Based Violence in Prisons
This group was asked to deliberate on:
   a) Manifestations of SGBV in prisons
   b) Possible interventions
   c) Possible stakeholders and partners in implementing the interventions

<table>
<thead>
<tr>
<th>Manifestation of SGBV in Prison</th>
<th>Possible Interventions</th>
<th>By Who</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Forms/ types of SGBV</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Rape/attempted rape</td>
<td>Creating awareness on rights to new inmates on arrival – KPS</td>
<td>KPS</td>
</tr>
<tr>
<td>b) Indecent assault</td>
<td>Continued awareness creation</td>
<td>KELIN</td>
</tr>
<tr>
<td>c) Consent to sexual acts through inducement/coercion/influence</td>
<td>Proper reporting mechanisms for inmates so that they are able to channel grievances for assistance</td>
<td>UNDP, KPS</td>
</tr>
<tr>
<td>b) Bullying by hardcore criminals</td>
<td></td>
<td>KELIN, Police</td>
</tr>
<tr>
<td><strong>Signs of SGBV</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Reported cases of rape</td>
<td>Need for capacity building of prison officers on SGBV issues</td>
<td>UNODC, KELIN</td>
</tr>
<tr>
<td>b) Withdrawal from the rest</td>
<td>Posting of clinical/medical officers to all stations</td>
<td>KPS</td>
</tr>
<tr>
<td>c) Physical abuse</td>
<td>Psychosocial support</td>
<td>KPS, NCA</td>
</tr>
<tr>
<td>d) Physical violence/ fights</td>
<td></td>
<td>MoH, Police</td>
</tr>
<tr>
<td>e) Harassment</td>
<td></td>
<td>Parteners, Counties</td>
</tr>
<tr>
<td>f) Used condoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g) Medical examination report</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

GROUP 3: Facilitating a Conducive Environment to Address HIV and TB Stigma and Discrimination among Prison Staff
This group was asked to respond to:
   a) Challenges resulting to HIV and TB stigma and discrimination among prison staff
   b) Possible interventions that can be undertaken to circumvent the challenges
   c) Possible stakeholders and partners in implementing the interventions

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Possible Interventions and by who</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Fear and unfavorable structures for accessing superiors</td>
<td>• Awareness creation by ACU, OIC</td>
</tr>
<tr>
<td>• Lack of confidentiality – culture of grapevine</td>
<td>• Training and sensitization on the HIV/TB issues by DPHS, ACU, partners</td>
</tr>
<tr>
<td>• Insufficient knowledge and focus on clients</td>
<td>• Provision of adequate structures on the ground by CGP, Regional Commanders</td>
</tr>
<tr>
<td>• Lack of support programs for harm reduction</td>
<td>• Implementing and enforcing relevant HIV and TB policies and guidelines by OIC, Regional ACUs, ACU</td>
</tr>
<tr>
<td>• Inadequate structures to address HIV/TB at station level</td>
<td>• Improve working relations so that superiors are more accessible to junior officers – OICs</td>
</tr>
<tr>
<td>• Inadequate capacity for service provision</td>
<td>• Formation of staff support groups and programmes – ACUs, Regional ACUs, OIC</td>
</tr>
<tr>
<td>• Lack of disclosure and fear of knowing status</td>
<td>• Instilling professional/ confidentiality and ethics among staff members – DPHS, OIC, ACU</td>
</tr>
<tr>
<td>• Discriminatory deployment of the infected</td>
<td>• Head of facilities to be more sensitive and empathetic towards the affected – OICs and staff</td>
</tr>
<tr>
<td>• Lack of proper awareness and sensitization i.e. TB</td>
<td>• Improve working environment by providing safety gear – DPHS, ACU, MoH</td>
</tr>
<tr>
<td>• Unsafe working environment (TB) / protective gear</td>
<td>• Involve partners in capacity building and provision of food supplements – partners, MoH, ACU</td>
</tr>
</tbody>
</table>
4.9 KPS Workplace Policy as a Tool to Facilitate Advancement of Rights in Prison

Facilitator: Samuel Ochieng (CIP); ACU Programmes Officer-Kenya Prisons Service

This session was geared to familiarize participants with the newly reviewed HIV and AIDS Workplace policy for prisons and how it promotes respect for HIV rights. The facilitator, Mr. Samuel Ochieng, explained that changing programmatic and legal environments necessitated review of the policy that had been developed in 2007. The main objective of the reviewed policy, he said, is to provide a framework to effectively address HIV and AIDS within the Kenya Prisons Service in contribution to the national HIV response. He added that by providing a framework, the policy allows individual prisons to customize it as per their specific HIV needs and priorities.

The specific objectives of the policy are to:

- Set Minimum Internal Requirements (MIR) for managing HIV & TB in the Department;
- Promote programmes to ensure non-discrimination and non-stigmatization of the infected and affected;
- Prevent new infections amongst prison staff, their dependents and prisoners;
- Mitigate the socio-economic impact of HIV and AIDS by ensuring access to social protection services including health insurance;
- Ensure provision of Prevention PMTCT services for pregnant mothers;
- Ensure expanded resource mobilization efforts and strategic partnerships to supplement government allocation to interventions;
- Guide prison staff and prisoners on their rights and obligations regarding HIV and AIDS within the country’s legal framework; and
- Create an environment conducive for research, capacity building, monitoring and evaluation.

The facilitator also mentioned that the policy is guided by constitutional provisions and international human rights instruments from which it derives principles of involvement of PLHIV and gender equality, among others. The policy also accords with the HIV and AIDS Prevention and Control Act by providing that HIV testing is not a prerequisite for recruitment and promotion at the workplace. In line with the policy’s human resource management provisions, the facilitator explained that some prisoners have been trained in cell-based care to be able to help fellow inmates in adherence to medication, peer education and management of support groups. Compassionate early release for prisoners on the basis of health status is also proposed in the policy.

Plenary

- A participant asked if compassionate early release is premised on grounds of HIV alone or if other medical conditions also qualified a prisoner for compassionate early release. At this point, participants were reminded that HIV does not of itself kill. It is the opportunistic infections and other life-threatening medical conditions that will be considered in compassionate early release.

- Still on compassionate early release, it emerged that the Advisory Committee on the Power of Mercy has not responded to recommendations by prisons for release of some prisoners on medical grounds. Terminally ill prisoners deserving the reprieve continue to languish in prisons.

- Participants then asked about the successes and challenges witnessed in the implementation of the previous HIV and AIDS Workplace policy. It was acknowledged that there had been weaknesses in the dissemination of the previous policy which hampered its effective implementation because awareness of its existence was low.

- In a rejoinder, the facilitator said that lessons had been learnt from the weaknesses in dissemination of the previous policy and assured participants that development of the new policy took on a participatory approach that involved a host of stakeholders, including prisoners. This he said will ensure support and ownership of the policy once it is rolled out and wide dissemination will be undertaken to create awareness on the existence of the policy.

- Plenary discussions also revealed that prisoners who had been involved in review of the zero draft of the new policy had indicated need for clear information on HIV and TB to be availed to them at the time of admission to prison.

- A participant proposed that the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (Bangkok Rules) be added on the list of international instruments that inform the reviewed policy. Also on the Bangkok Rules, one participant informed the rest that the Prisons’ Legal Department was working on a simplified version of the Rules which can be shared along with the workplace policy.

- In order to exercise vigilance against contravention of the policy, a participant wanted to know what complaint mechanisms in the prisons can be used to enforce the policy. He was answered that KPS has Directorates of Administration and Complaints both to which the policy will be disseminated for purposes of managing complaints within the policy framework.

- A participant inquired of the reviewed policy’s provisions on Hepatitis B. He was concerned that Hepatitis B was the main hepatitis troubling injecting drug users and that prison officers were also at a high risk of contracting it. The response to this was that prison officers will continue to be trained on specific issues such as this, depending on the gravity of the issue in a particular prison. Vaccination of prison staff and prisoners against hepatitis B was considered to be the ultimate solution to this health challenge if the required financial resources are mobilized.

- An emerging issue discussed was the challenge in managing HIV and STIs among female prisoners. Sexual practices among women in prison were unknown and hence there was need to generate evidence and document more information with the objective of informing appropriate interventions.
4.10 Recommendations of the Global Commission Report on HIV and the law and their Relevance to Prisons Officers and Inmates

Facilitator: Melba Katindi; Programme Officer - KELIN

This session consolidated key points to be picked from the workshop after two days of deliberations on HIV and TB rights in prisons. The facilitator reiterated the link between human rights and HIV and the role of the law in creating an enabling environment for realization of HIV rights. While the law alone cannot stop the spread of HIV, participants learnt that laws creating an enabling environment for fulfillment of HIV rights can prevent 1 million people worldwide from getting infected with HIV. As a way forward thus, participants were urged to bear in mind the recommendations from the report of the Global Commission on HIV and the Law as they ponder opportunities to advance HIV and TB rights in a legal environment that is not the most supportive.

The following findings of the Commission on the role of the law in protecting HIV rights were highlighted:

- Epidemic of bad laws is fueling the spread of HIV, resulting in human rights violations and costing lives.
- Epidemic of bad laws is wasting money and limiting effectiveness and efficiency of HIV and health investments.
- Good laws and practices that protect human rights and build on public health evidence already exist – they strengthen the global AIDS response, and they must be replicated.

To put into context the role of the law in HIV response, participants were read for an excerpt from the Commission’s report: “When the law punishes drug use, sex work, and certain sexual behaviors and identities, key populations can neither count on the law enforcement officers for protection from violence nor seek legal redress when they are its victims, especially when the perpetrators are police officers.”

The facilitator, Ms. Melba Katindi, cited numerous opportunities for the Kenya Prisons Service to link HIV prevention, treatment and care programs in prisons to the national HIV, TB and public health programs for prisoners and staff working in prisons without discrimination. The Global Fund new funding model and the development of the national HIV & TB strategic plans provides KPS a timely opportunity to can get involved in ongoing processes to ensure prison settings are included as key areas of focus in the national response.

4.11 Law Enforcement and HIV

Facilitator: Wilson Edung’ Lomali; Kenya Focal Point-LEAHN

LEAHN is a global network that helps professionals understand the role of law enforcement in public health and the importance of collaborative responses to reducing the incidence of HIV. This is a section of law enforcement officers that have heeded the recommendations from the report of the Global Commission on the Law and HIV. In a bid to fast track implementation of the recommendations that touch on the role of law enforcers in protecting HIV rights, the officers have formed a global network of likeminded country sub-networks. Kenya is yet to establish a sub-network of its own but has a focal person in the global network, Chief Inspector Wilson Edung’ Lomali, himself a law enforcement officer with the Kenya Police Service.

Chief Inspector Edung’ rallied the support of prisons officers at the training for the establishment of network of law enforcement officers to champion issues around HIV and the law. Such a network would promote locally-driven approaches which would be most effective to address HIV and TB and addressing concerns around violence against sex workers and injecting drug users that increase their vulnerability to HIV.

At the end of Inspector Edung’s address, participants were agreeable to establishment of a Kenyan Law Enforcement and HIV Network and requested for technical and financial support in setting up and programming.
5.0 TRAINING METHODOLOGY

The training adopted a participatory learning process that facilitated information sharing and enriched the learning experience of participants. Training methodologies used included:

a) PowerPoint presentation from experts on HIV and TB programming, human rights and the law.
b) Panel discussions involving representatives of persons living with HIV, TB patients, law enforcement officers with experience in the law to protect and promote the human rights of people living with HIV and members of key populations.
c) Moderated discussions on topical issues identified.
d) Buzzing in small tables.

6.0 RECOMMENDATIONS

Recommendations coming from participants during the 3-day workshop were:

Advocacy
1. Need for prison specific HIV and TB policies fit for their unique setting
2. Post-release follow up on prisoners especially those started on TB medication
3. Recruitment of more skilled medical personnel in prisons
4. Advocacy targeting County governments towards ensuring access to health services for prison populations
5. Need to promote the use of non-custodial sentences to decongest prisons
6. Review imprisonment of TB treatment defaulters and consider alternative interventions
7. Advocate for availability of hepatitis B vaccination of prisoners and prison staff

Practice
1. Involvement of prison officers as stakeholders in the formulation and review of national HIV and TB policies as the prison setting presented unique health challenges
2. Enhance nutrition and diet supplementation for sick prisoners
3. Implement a comprehensive SGBV response package in prisons
4. Infuse a human rights-based approach in management of PLHIV, sex workers and IDUs in prison by using non-derogatory language, listening to their concerns, and ensuring confidentiality of HIV status
5. Encourage use of lived experiences and mixed support groups between prison staff and prisoners to influence behaviour change and reduce stigma and discrimination
6. Establishment of the Kenyan chapter of Law Enforcement and HIV Networks (LEAHN)
7. Greater involvement of all stakeholders in decision making, including prisoners

7.0 WAY FORWARD AND ACTION PLANS

Owing to the large number of recommendations, participants picked on a few and generated action plans for immediate implementation, going forward. These were:

1. Develop a plan and design tools for research and documentation for purposes of generating evidence from prisons on gaps and capacity building needs on issues relating to human rights in HIV and TB covered during the workshop.
2. Based on the findings of the needs analysis, the action plans developed by the various groups (Refer to Session 4.8) would be prioritized for fundraising and implementation.
3. KPS ACU to establish a database of persons trained on HIV and TB rights so as to ensure a coordinated approach in capacity building forums by different partners.

8.0 CHALLENGES

1. Three days scheduled for the workshop seemed not be sufficient time to exhaust all the issues that came for deliberation. Some workshop sessions consequently extended beyond the allocated timeframes to accommodate deliberations.
2. A section of participants took offence with a facilitator who proposed to use a hypothetical case scenario that did not depict the true picture of prison policy in Kenya.

9.0 CONCLUSION

The workshop ended with a vote of thanks from KPS followed by certification of participants.
### APPENDIX 1: LIST OF PARTICIPANTS

<table>
<thead>
<tr>
<th>No.</th>
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<tr>
<td>1</td>
<td>Aggrey Onyango</td>
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APPENDIX 2: WORKSHOP AGENDA

CAPACITY BUILDING WORKSHOP ON HUMAN RIGHTS AND THE LAW IN RELATION TO HIV AND TB IN PRISON
SILVER SPRINGS HOTEL, NAIROBI,

14 to 16 October 2014

AGENDA

The objectives of this training are to:

i. Enhance the participants’ understanding on human rights and the law impacting on HIV and TB response in prison.

ii. Increase the participants’ awareness on sexual and gender based violence, exploitation and all forms of victimization in prison especially among women.

iii. Discuss the role of prison officers in upholding the rights of person living with HIV and TB with emphasis on members of key and affected populations and women living with HIV.

Monday, 13 October, 2014

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Day 1 Tuesday, 14 October, 2014

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<td>Pre-evaluations, expectations and climate setting</td>
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<td>Opening Remarks, NEC, KPS, UNDP, NASCOP</td>
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<td>Burden of HIV and TB in prison - Statistics and Updates from Prisons</td>
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<td>9:30 - 10:30 am</td>
<td>Overview of HIV and TB: Development in HIV and TB, Prevention and treatment strategies for prison populations</td>
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<td>HIV and TB related Stigma and discrimination and its role in HIV testing, prevention and treatment</td>
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<td>Group session: Stigma and Discrimination affecting law enforcement officers in relation to HIV and TB – Challenges &amp; Recommendations</td>
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<td>2.00 – 3.00 PM</td>
<td>Addressing sexual and gender-based violence affecting women and all forms of victimization in prison</td>
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<td>4.00 – 5.00 pm</td>
<td>Case Studies – Moderated panel discussion (Imprisoned TB defaulter, Former prisoners – IDU, HIV, TB, Expectant Mother, MSM)</td>
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**Day 2 Wednesday, 15 October, 2014**

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<td>Recap</td>
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<td>Overview of Human Rights and how the Constitution of Kenya advances the rights of PLHIV and TB patients</td>
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<td>Legal and Ethical considerations that impact on the HIV and TB response in Prisons</td>
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<td>2.00 – 3.00 pm</td>
<td>Opportunities for Rights based interventions for HIV in Prison</td>
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<td>4.00 – 5.00 pm</td>
<td>Group Discussion – The role of prisons officers in enforcing the rights of PLHIV and TB patients in the Prison setting – Challenges and Recommendations</td>
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**Day 3 Thursday, 16 October, 2014**

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<td>Recommendations of the Global Commission Report on HIV and their relevance to Prisons officers and inmates</td>
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<td>9.00 – 9.30 pm</td>
<td>Opportunities for Rights based interventions for TB in Prison</td>
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<td>KPS workplace policy as a tool to facilitate advancement of rights in prison</td>
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<td>11.00 – 12.00 pm</td>
<td>Group work: Prioritization of issues to enhance rights based HIV and TB interventions in prison, development of actionable plan and identification of possible partners</td>
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APPENDIX 3: LIST OF RESOURCE PERSONS

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APPENDIX 3: CONCEPT

CAPACITY BUILDING WORKSHOP FOR SENIOR PRISONS OFFICERS ON RIGHTS BASED MANAGEMENT OF HIV AND TB

CONCEPT NOTE

1.0 Introduction and Background

According to the Kenya AIDS Estimates 2014 by the Ministry of Health, an estimated 1.6 million people were living with HIV in Kenya in 2013: a prevalence rate of 6% with approximately 88,620 new HIV infections that occurred among adults and 12,940 among children in 2013. An estimated 58,465 people died of AIDS-related causes in 2013. Despite being both curable and preventable, TB remains the leading cause of death of people living with HIV in Kenya. The country is ranked 15 among the 22 high TB burden countries in the world.

According to KaIS 2007 - Kenya’s first-ever study to estimate new infections by modes of transmission – it was established that prison inmates have among the country’s highest rate of HIV transmission, with men who have sex with men in prisons contributing to 15.2% of the new HIV infections in Kenya. This study revealed that the prevalence among inmates in Kenya is higher than the national average of 5.6%; with an estimated 19% among female inmates and 5.5% among male inmates. The inmates who suffer from communicable diseases like TB also pose a great danger to prison staff and fellow inmates while they are confined in the overcrowded prisons with poor ventilation; and the practice of imprisoning TB treatment defaulters further aggravates the situation in light of growing concerns about the increase in resistant strains of TB in Kenya.

Limited data regarding HIV prevalence and risk factors in the prison population in Kenya or HIV-related risks in prisons settings affects the development and implementation of adequate prevention, treatment, care and support programmes. Although gender-based violence (GBV) is one of the driving forces of the HIV epidemic worldwide; prison settings do not usually address gender-specific needs. Sexual Violence is used by staff and inmates for punishment, intimidation and discrimination. While any person may become a victim of prison rape, the risk is higher among women staff and prisoners and men prisoners who do not fit masculine stereotypes, such as those who are physically weak, not prepared to use violence or that were incarcerated for non-violent crimes.

http://www.icad-cisd.com/pdf/Gender_Based_Violence_EN.pdf

Empowered lives. Resilient nations
In order to ensure an effective, sustainable response to HIV that is consistent with human rights obligations, the Global Commission on HIV and the Law in their report Risks, Rights and Health recommends that countries must ensure that health care is available in places of detention, including HIV prevention and care services, regardless of laws criminalizing same-sex acts or harm reduction. The Kenya Prisons Service has a workplace policy on HIV and AIDS that aims to address issues affecting prisoners, prison staff, their families and the surrounding communities. It is important that senior officials understand the rights and responsibilities expected of them in order to effectively address and mitigate concerns relating to HIV and TB in prison.

2.0 Justification

The government is obligated to provide a safe working environment for health care workers in order to guarantee long-term benefits to health service provision for TB patients. Article 43(1) (a) of the Constitution of Kenya 2010 guarantees the right to the highest attainable standard of Health for all. Government authorities are additionally obligated under Article 51 of the Constitution, 2010 to safe guard the rights of persons detained: held in custody or imprisoned. Persons in prison have a right to a standard of health care equivalent to that available outside of prisons. Articles 27 and 41 additionally guarantees the right to equality and non-discrimination and fair labour practices which prison staff are entitled particularly where their health is concerned. The prison population has the right to access a comprehensive package of HIV and TB in line with the national response including rights based responses to address specific needs for these men and women.

An environment where human rights are not respected inhibits ability to access essential HIV and TB related health services, and thus increases vulnerability to HIV and TB infection. The prisons HIV and TB response should reflect commitment to rights-based approaches and evidence-informed action. The process of the implementation of the Constitution presents a timely opportunity to develop prisons laus and policies that are informed by evidence of what works for the effective management of both epidemics. High-ranking officials can challenge practices that contribute to the high burden that HIV and TB place on the limited resources. They have an obligation to review logistical, legal, and financial restrictions that pose a challenge to the provision of effective HIV and TB services in Kenyan Prisons. In order to participate and be meaningfully involved in HIV and TB program planning and implementation there is need to understand key principles governing the recognition and response of HIV and TB in their place or work. Staff in correctional settings may face unique confidentiality and reporting requirements and hence should be familiar with relevant legal and human rights framework to inform practice. Prison programs should address gender specific risks inside and outside of the prison settings in order to mitigate HIV and TB related risks in support of Kenya’s broad health goals.

Prisons officials are therefore important partners in preventing and managing HIV and TB to protect and improve the health of the entire prison population and their communities. Ensuring continuous legal and human rights education of prison staff, prisoners and detainees is necessary to maximize cooperation and participation in promoting both individual and public health.

3.0 Objectives of the Workshop

The workshop brings together senior law enforcement officers with a view to:

d) Enhance the participants’ understanding on human rights and the law impacting on HIV and TB response in prison.
e) Increase the participants’ awareness on sexual and gender-based violence, exploitation and all forms of victimization in prison especially among women.
f) Discuss the role of prisons officers in upholding the rights of person living with HIV and TB with emphasis on members of key and affected populations and; women living HIV.

4.0 Expected Outcomes

The expected outcomes are that senior prisons officials will have:

d) Increased awareness among senior prisoners officers on the role of the law and the law enforcement officers in protecting the rights of people living with HIV and those infected with TB within their custody.
e) Enhanced commitment to implement measures to protect and address sexual and gender-based violence in prison.
f) Buy in, commitment and specific proposals to advance rights based and evidence informed HIV and TB interventions - taking into account specific needs of the different populations in prison and the available opportunities.

5.0 Methodology

The training will adopt a participatory learning process to facilitate information sharing and enrich the learning experience of participants that will include:

- PowerPoint presentation from experts on HIV and TB programming, human rights and the law.
- Panel discussions involving representatives of persons living with HIV, TB patients, law enforcement officers with experience in using the law to protect and promote the human rights of people living with HIV and members of key populations.
- Moderated discussions on topical issues identified.
- Buzzing in small tables.

6.0 Participants

The workshop primarily targets senior prisons officers from the counties of Kilifi, Mombasa, Nairobi and Kisumu counties. This opportunity will also be extended to representatives from Prison facilities in Homabay, Nakuru and Uasin Gishu, representatives from other law enforcement agencies and key stakeholders working in prison who could also benefit from this process.

7.0 Venue and Date

The three-day residential workshop will take place from 14 to 16 October, 2014 at the Silver Springs Hotel Nairobi.

8.0 Conveners

The training is convened by KELIN in partnership with the KPS working in close consultation with NEPHAK, NACC, NASCOP, UNAIDS and other partners with support from UNDP.