Tuberculosis: An Assessment of the Legal Environment

KENYA

REPORT
January 2018

KELIN
Reclaiming Rights, Rebuilding Lives

Stop TB Partnership

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STOP
TB
STIGMA
#TB
is not a crime
Promote adherence

ABBREVIATIONS

AIDS	Acquired Immuno Deficiency Syndrome
CAT	Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
CHVs	Community Health Volunteers
CSOs	Civil Society Organizations
CRPD	Convention on the Rights of People with Disabilities
DLTLD	Division of Leprosy, Tuberculosis and Lung Disease
DOT	Directly Observed Treatment
FGDs	Focus Group Discussion
HBCs	High Burden Countries
HIV	Human Immuno-Deficiency Virus
ICCPR	International Covenant on Civil and Political Rights
ICERD	International Convention on the Elimination of All Forms of Racial Discrimination
ICESCR	International Covenant on Economic, Social and Cultural Rights
IPT	Isoniazid Preventive Therapy
KELIN	Kenya Legal and Ethical Issues Network on HIV and AIDS
KIIs	Key Informant Interviews
MDR-TB	Multidrug-resistant Tuberculosis
MOH	Ministry of Health
NGO	Non-Government Organisation
OPP	Out of Pocket Payments
PLHV	Person living with HIV/AIDS
TB	Tuberculosis
WHO	World Health Organisation
XDR-TB	Extensively drug-resistant Tuberculosis

ACKNOWLEDGMENTS

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Allan Maleche

Executive Director (KELIN)

EXECUTIVE SUMMARY

Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN) with financial and technical support from Stop TB Partnership Secretariat (Stop TB) piloted a legal environment assessment for Tuberculosis (TB) in Kenya. The purpose of this assessment was to examine the national legal and policy framework of TB in Kenya and identify legal and human rights issues in TB affecting people. It is appreciated that in the area of TB prevention and control, legal and policy barriers might not be as obviously problematic to treatment and care as they are in the area of HIV.

However, human rights and law issues have emerged and should be addressed through country-level reviews of laws and policies. These issues have increasingly presented barriers to access to the best standards of care for TB patients, especially the marginalized communities. This Report provides a summary of the TB situation in Kenya, the Legal and Policy Framework, and the key research findings of the assessment. The Assessment identified multiple protections for people with TB that already exist within the national legal framework. The Kenyan Constitution guarantees rights and freedoms including right to health,[1] privacy,[2] life,[3] dignity,[4] non-discrimination,[5] access to information,[6] consumer rights,[7] all of which can be used to protect a person with TB.

However, this assessment also identified several other laws and policies that have inadequate protection for the rights of people with TB. The Public Health Act is the most problematic for people with TB as it still contains provisions that criminalize TB and has not embraced a rights-based approach in TB management. This essentially means the Act is yet to embrace a participatory and inclusive approach in public health management issues, with provisions focusing more on medical aspects and less on community initiatives. Stakeholder interviews demonstrated that despite rather advanced support for patients' rights in Kenya, a rights-based approach is yet to be realized in the prevention, treatment, care and support of people with TB. While treatment of TB is free, people with TB still incur costs related to diagnosis such as x-rays.

The stigma surrounding TB still prevails in Kenya with poor dissemination of information about TB and lack of involvement of communities of TB survivors in decision making processes. The lack of guidance on isolation of patients, and the non-existence of isolation units is a loophole for possible human rights violations of people with TB. Further, there is hardly any guidance on addressing TB related discrimination and violation of human rights at the facility and policy level. TB related discrimination particularly impacts those who are most vulnerable – children, migrants and seasonal workers, health workers, prisoners, and urban and rural poor.

1 Article 43 Constitution of Kenya
2 Article 31 Constitution of Kenya
3 Article 26 Constitution of Kenya
4 Article 28 Constitution of Kenya
5 Article 27 Constitution of Kenya
6 Article 35 Constitution of Kenya
7 Article 46 Constitution of Kenya

PART I: RECOMMENDATIONS
A: Recommendation to the National Government

1. Recommendations for legal review

- The High Court decision in *Petition 329 of 2014 Daniel Ng'etich & Others v. Attorney General & others* found the unlawful and unconstitutional use of Section 27 of the Public Health Act (Chapter 242 of Laws of Kenya) to imprison TB patients to be a violation of their rights. This warrants the need to review and amend Section 27 and 28 of the Public Health Act in order to integrate a rights-based approach, and ensure it conforms to the Constitution and existing international standards.
- Further, sections 17 and 18 of the Public Health Act contain problematic notification requirements that need to be reviewed and revised to protect the privacy, confidentiality and other human rights of the patient. The punitive nature of these provisions exacerbates stigma and discrimination of persons with TB.
- Section 29 of the Prisons Act needs to be reviewed to ensure that rights to informed consent, privacy and confidentiality are protected when providing medical services to prisoners. The Act also needs to clearly indicate rights of prisoners, in line with the Constitution. Relatedly, Guidelines should be developed to ensure that prisoners are provided with quality TB services, including prevention, diagnosis, treatment and care (in and out of prison).
- Guidelines need to be developed for the *Persons Deprived of Liberty Act* to ensure that the disclosure under section 16 (2) of the Act is implemented in a manner that respects rights to privacy and confidentiality, and does not lead to stigma, discrimination and violence.[8]
- The Employment Act needs to be reviewed to accord greater protection to casual labourers, especially on access to medical services and sick leave.

2. The National Tuberculosis, Leprosy and Lung Disease Program (NTLDP) should develop a structured mechanism for meaningful engagement with stakeholders, especially TB patients and affected communities, in formulation of laws, policies, guidelines and operating procedures impacting the TB response. Engagement should include representation from all regions and key and vulnerable populations.
   - The Program should engage TB patients and affected communities in determining the nature of this structured mechanism. Public participation is a constitutional requirement that binds all State organs.[9]
3. The Ministry of Health should scale-up collaboration with other government ministries including Ministry of Labour, Education, Gender and Social Protection, Interior and Co-ordination of Government, Transport, among others to review and integrate TB management in their guidelines.
4. The National Tuberculosis, Leprosy and Lung Disease Program should work with stakeholders to safeguard the rights of TB key, vulnerable and underserved populations. Since the lack of adequate data on these populations threatens programming and development of protective measures, the NTLDP should put systems in place which collect disaggregated TB data for key and vulnerable populations, to ensure that programs are evidence-informed and respond to their specific needs.[10]

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8 .Section 16 (2) of the Act provides:

Notwithstanding the provisions of subsection (1), a medical officer of health shall disclose to the law enforcement official in charge of an institution, health information of a person deprived of liberty which relates to infectious or communicable diseases in order to—
(a) facilitate effective health care for the person deprived liberty ; and
(b) facilitate the protection of other persons deprived of liberty and the officers under whose charge such persons are accommodated.

9 See Article 10 Constitution of Kenya.

10 Stop TB Partnership has developed a Data for Action Framework for Key, Vulnerable and Underserved Populations to guide the collection of disaggregated TB data for key and vulnerable populations.

5. The National Tuberculosis, Leprosy and Lung Disease Program should ensure that TB diagnosis and treatment is easily accessible and available in health facilities to safeguard TB patient's right to health care through making available appropriate diagnostic tools (e.g. GeneXpert machines and Lipoarabinomannan or LAM test). NTLDP should also ensure that newer and high quality TB drugs are available in health facilities.
6. The NTLDP should fast-track development of an isolation policy to guide voluntary and involuntary isolation of TB patients with challenges adhering to medication. The development of the policy should be guided by WHO Ethics Guidance for the Implementation of the End TB Strategy11 that:

- TB treatment should be provided on a voluntary basis, with the patient's informed consent and cooperation;
- Involuntary isolation should never be a routine component of TB programmes;
- Least restrictive isolation measures should be taken at all times;
- Involuntary isolation decisions should be made in a transparent fashion with appropriate opportunities for external review and appeal. Involuntary isolation should meet the following conditions:

    - Isolation is necessary to prevent the spread of TB, AND
    - Evidence that isolation is likely to be effective in this case, AND
    - Patient refuses to remain in isolation despite being adequately informed of the risks, the meaning of being isolated and the reasons for isolation, AND
    - Patient's refusal puts others at risk, AND
    - All less restrictive measures have been attempted prior to forcing isolation, AND
    - All other rights and freedoms (such as basic civil liberties) besides that of movement are protected, AND
    - Due process and all relevant appeal mechanisms are in place, AND
    - Patient has, at least, basic needs met, AND
    - The isolation time given is the minimum necessary to achieve its goals.

- The policy should also provide clear procedures and definitions as to the scope of duties and responsibilities in decision-making when isolation is considered, to empower health workers to protect the rights of patients and carry out their duties effectively.

7. The National Tuberculosis, Leprosy and Lung Disease Program should fast-track development of a social protection policy for protection of social well-being of TB patients, especially MDR and XDR-TB patients, from the catastrophic effects of TB medication. The Social Protection policy should integrate international standards to cover protection against: general poverty and social exclusion, lack of affordable access to health care, lack of labour market protections, as well as a lack of work-related income.
8. The National Tuberculosis, Leprosy and Lung Disease Program should scale up educational programmes and campaigns and disseminate information on scientifically accurate TB-information in schools, health institutions, and any other appropriate settings which are widely available to the public.
9. Institute safeguards to ensure that TB test status does not affect a person's employment status, immigration status or qualification for other government benefits or services. This can be achieved through implementation of firewall policies between public health services and other state functions such as immigration and border control.

11 Chapter 15 *WHO Ethics Guidance for the Implementation of the End TB Strategy* "Isolation and Involuntary Isolation"

10. Ensure that key, vulnerable and underserved populations (including miners, prisoners, drug users, children) right to access health services is promoted and protected, and that legal, policy, practice or any other barrier that may hinder access to quality health services are removed.

B: Recommendation to County Governments

1. County Health Departments should develop structured mechanisms to support TB patients and community-based health systems. The Counties should work towards integration of community health volunteers (CHVs) who support TB patients in the treatment cascade, and ensure the remuneration, training and professional development of the CHVs.
2. County Health Departments should, through education, sensitizations and training programmes, urgently address negative practices at health facilities. Relatedly, the incorporation of patient-centred approaches in *Service Charters* of county facilities will ensure greater access to medical services by TB patients. The negative practices include, for example, unreasonable delays in serving patients and poor attitude of health care workers. These impacts negatively on health seeking behaviour.
3. Ensure health care workers mainstream rights-based approach in their work, including:

- Inform and counsel patients about TB and/or differential diagnoses pre and post screening and testing
- Protect patient confidentiality (eg, share test results in private)
- Advise patients of their right to access treatment

C: Recommendation to Civil Society Organisations

1. Civil Society Organizations working to protect rights of TB patients and the Affected Communities should, in partnership with people with and affected by TB and communities, advocate for their inclusion in processes relating to formulation of laws, policies, guidelines and standard operating procedures to ensure they are participatory and evidence-informed.
2. CSOs should work closely with affected persons and communities and ensure their inclusion and participation to monitor implementation of TB-related health services and programmes at national, county and facility level to ensure quality provision of TB services and sufficient supplies, including for diagnosis, treatment and prevention.
3. CSOs should develop mechanisms for monitoring, documentation and reporting of rights violations of TB patients.
4. CSOs should work with human rights and other relevant institutions to ensure that legal support and services are provided to TB patients who face discrimination or rights violations. The Legal Aid Act (No. 6 of 2016) provides an important avenue for advocacy to ensure access to justice for TB patients to realize their rights.
5. CSOs should undertake capacity building programmes to increase knowledge of affected communities on human rights, and further support communities to form networks for effective advocacy for the protection and promotion of rights of TB patients.
6. CSOs should advocate for increased public education and sensitization programmes as a strategy for reduction in stigma and discrimination.

PART II: BACKGROUND, METHODOLOGY AND SUMMARY

2.1 Introduction

TB remains a major global health problem. It ranks as the leading cause of death from an infectious disease, ranking above the human immunodeficiency virus (HIV). In 2016, there were an estimated 1.3 million TB deaths among HIV-negative people (down from 1.7 million in 2000) and an additional 374,000 deaths among people living with HIV. An estimated 10.4 million people (90% adults; 65% male; 10% people living with HIV) fell ill with TB in 2016 (i.e. were incident cases).[12]

Nearly 80% of the global burden of TB is found in 22 countries and nine countries in Sub–Saharan Africa belong to the 22 high burden countries (HBCs). In 2013, Africa contributed 12.7% of the world population, 24.5% of TB deaths and 78.1% of HIV-positive TB related deaths. Kenya is ranked 10th among the 22 high TB burden countries. Due to the infectious nature of TB, measures to prevent, manage, and treat the diseases have led to undesirable violations of human rights of TB patients. A good example was the practice of arrest and detention in prisons of persons suspected of having defaulted on their TB medication in Kenya.[13] This necessitates the need for advocacy to integrate a human-rights based approach to TB prevention, management, and treatment.

A human rights-based approach to TB articulates the rights of people living with and vulnerable to TB, including the rights to life, health, nondiscrimination, privacy, informed consent, housing, food and water. The approach focuses on the social and economic determinants of the disease.

12World Health Organization (WHO) (2017) *Global Tuberculosis Report 2017* available at http://apps.who.int/iris/bitstream/10665/259366/1/9789241565516-eng.pdf (accessed on 21 December 2017).

13 See Susan Anyangu-Amu (2010) "Kenya: TB Patients Held in Prison," *Inter Press Service*, Sep 13 2010; *Agnes Aboo (2016) "*Man to serve 6 months in jail for refusing to take TB drugs," *Daily Nation* Thursday January 21 2016; **Steve Gatheru/Patrick Kiboi (2014) "**TB patient remanded for defaulting on treatment," *Kenya News Agency* May 19, 2014.

It articulates the domestic and international legal obligations of governments and non-state actors to ensure quality testing and treatment for TB is available and accessible without discrimination. The approach aims to create an enabling legal environment for the research and development of new tools for managing TB. A rights-based approach requires that special attention be paid to the needs of groups most vulnerable to TB in the design and implementation of health policies, including the poor, people living with HIV, prisoners, migrants, women, children, and people who use drugs.[14]

The approach also encourages and facilitates the active and informed participation of affected individuals and communities in decision-making processes affecting their health. A rights-based approach has been applied successfully to HIV prevention and treatment throughout the world. The mobilization of affected communities in grassroots campaigns has spurred research and development of new medicines and lowered the prices of existing drugs. People living with HIV have claimed their rights to information, participation, and informed consent, and won greater protections against discrimination through litigation and advocacy based on constitutionally derived human rights.

2.2. Purpose

It is against this backdrop that the Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN) with financial and technical support from Stop TB Partnership Secretariat (Stop TB) piloted a legal environment assessment for TB in Kenya. The legal environment assessment entailed an assessment of the national legal and policy framework of TB in Kenya. It aimed at identifying and examining all important legal and human rights issues in TB affecting people.

14 The Global Fund (2016) *Tuberculosis Information Note*

It is appreciated that in the area of TB prevention and control, legal and policy barriers might not be as obviously problematic to treatment and care as they are in the area of HIV. However, human rights and law issues have emerged and should be addressed through country-level reviews of laws and policies. These issues have increasingly presented barriers to access to the best standards of care for TB patients, especially the marginalized communities.

KELIN, with support from Stop TB Secretariat was tasked with:

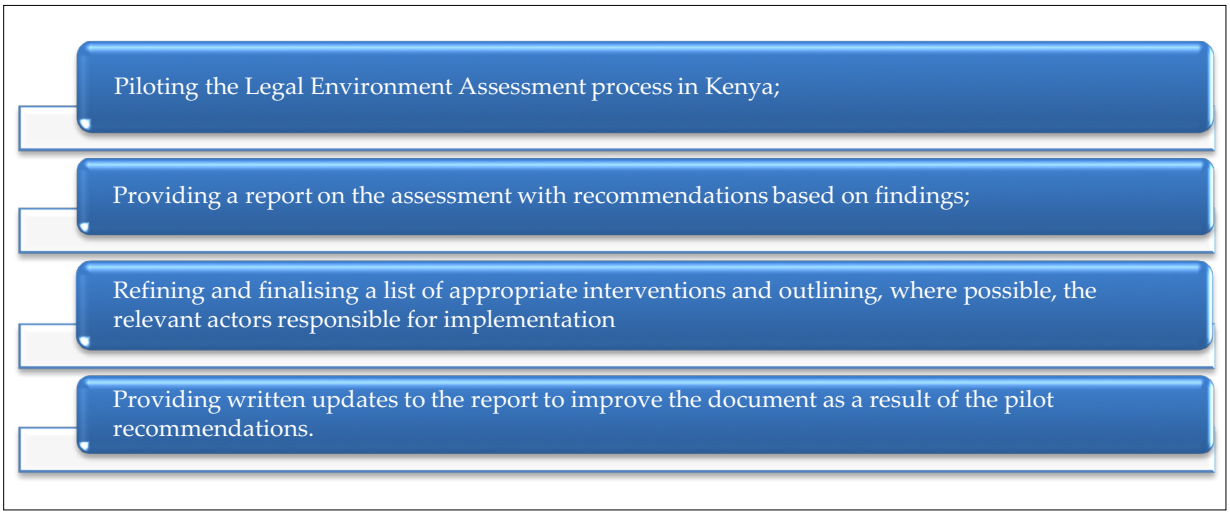

Figure 1: KELIN, with support from Stop TB Secretariat tasks

2.3. Methodology

This section outlines the approach used for this legal environment assessment. It contains the research design, the sample selection, research tools/instruments, data collection, management and analysis. The research process started with desk review, and development and adoption of the study concept note and data collection tools. *Summary of LEA process in Kenya*

LEA Process in Kenya	Mapping out of stakeholders	After the LEA, what next?
Mapping out of stakeholders	▪ Communities affected by TB	Recommendations based on findings
Desk and literature review	▪ Civil Society and community based organizations working on TB, HIV and Human Rights ▪ Key, vulnerable and underserved populations	Appropriate interventions – and who is responsible for implementation
Field interviews with Key informants	▪ National TB, Leprosy & Lung Disease Programme (NTLD); ▪ County and Sub-County TB Co-ordinators	Provide written updates to the LEA
Focus Group Discussions	▪ Service Providers – health care workers, national and county referral hospitals	
Multi-stakeholder Community dialogue	▪ Other critical players: Prisons Service, Ministry of Labour, Ministry of Education, Private Sector, Development partners	
Validation of the draft report Launch of Report		

Table 1: Summary of LEA process in Kenya

Desk Review

The **Desk Review** process interrogated the following documents or categories of documents that are relevant to TB:

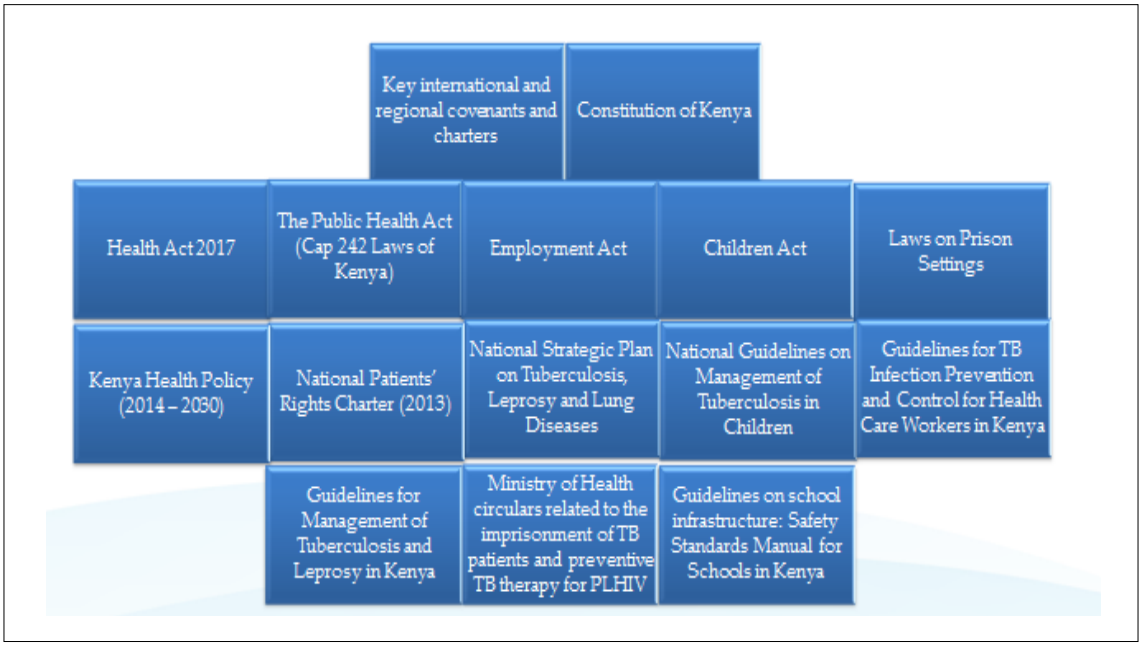

Figure 2: Summary of laws, policies and guidelines reviewed in this assessment

Field Research Design

This assessment utilised the qualitative technique for data collection and analysis. Qualitative research is usually non-statistical, non-representative and exploratory and commonly measures perceptions, beliefs, opinions, and behaviours of populations using in-depth interviews, group discussions, mapping or observation. The targeted stakeholders included both government and county government representatives working in TB departments, health care workers, communities of TB patients, civil society representatives, and development partners, among others.

Mapping of stakeholders

Purposive sampling was used to select participants for the qualitative study. A Focus Group Discussion (FDG) was conducted with former TB patients not included as key informants. The FGD comprised of 11 participants who comprised of former TB patients who were also recovering injecting drug users.

A community multi-stakeholder dialogue forum was also conducted among stakeholders representing four TB high burden counties (regions) in Kenya. These were Busia, Kisumu, Homa Bay and Kakamega counties where 45 participants including civil society, county and sub-county TB coordinators, community health workers, former TB patients, service providers, among others, provided information on practices at the community level.

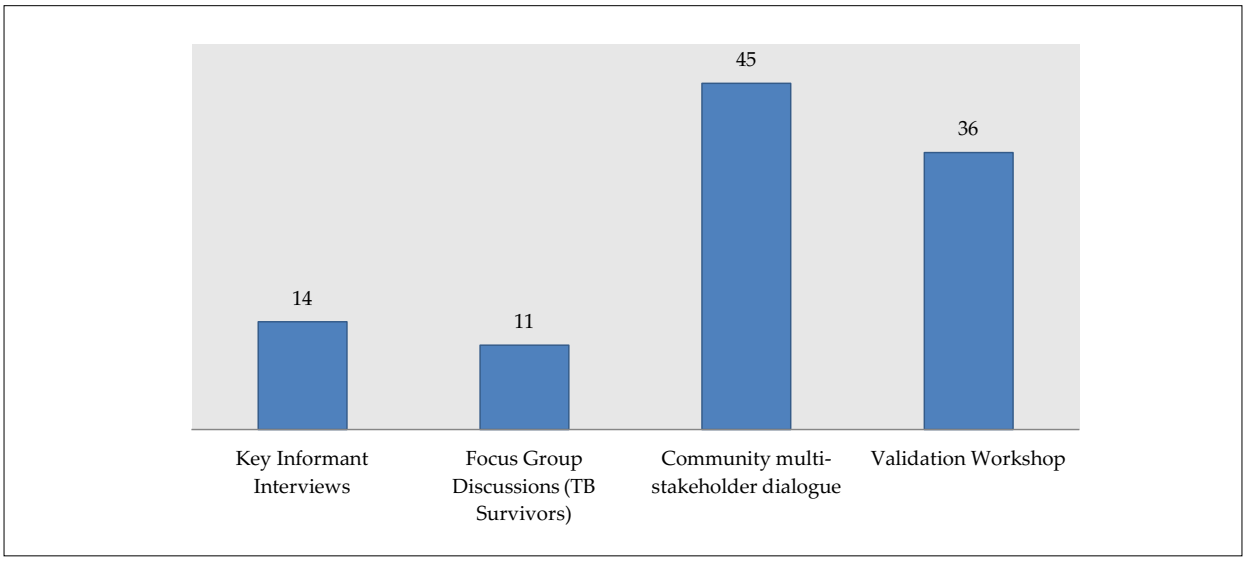

Figure 3: Graphical representation of number of stakeholders engaged in various stages of the assessment.

Respondents by numbers

A total of 14 key informant interviews (KIIs) with selected groups of stakeholders and partners were conducted. Key informant interviews were conducted with the Acting Head of the TB Programme in Kenya, County TB coordinators, health care workers from hospitals in Mombasa, Kisumu, and Nairobi counties, Ministry of Labour, Civil Society Organisations, former TB Patients and Research Institutions. The interviews were tape recorded and transcribed verbatim. The purpose of the study was clearly explained and consent obtained for participation and recording of the discussions. Ground rules for the discussions were explained and agreed upon and respondents given an opportunity to ask any questions. The transcripts were submitted for analysis.

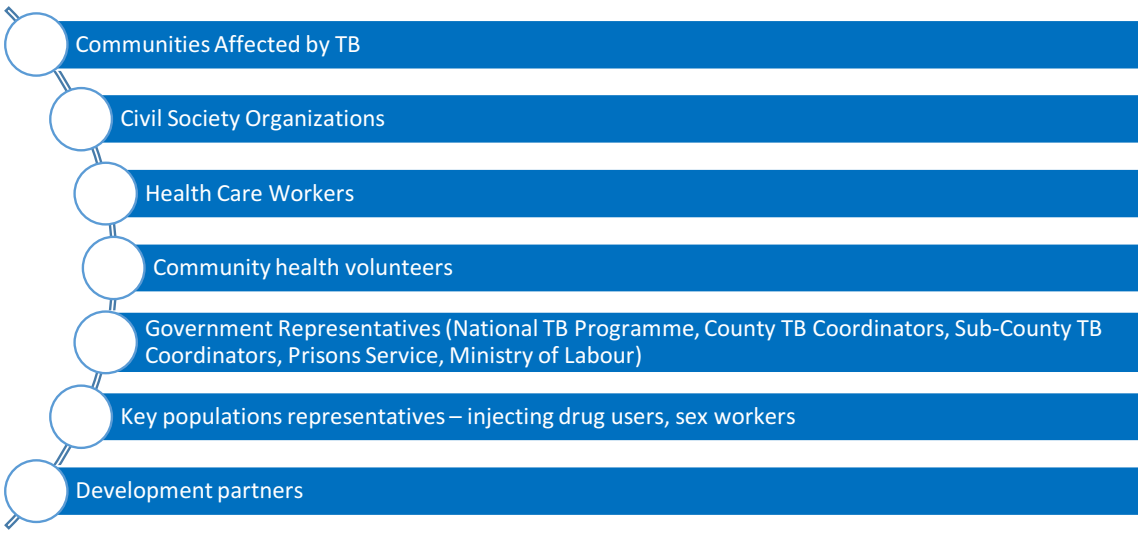

Figure 4: Summary of various stakeholders consulted during this assessment

Community TB Champion, Stephen Anguva outside Mililimani Law courts

Data analysis

In analysing the qualitative aspect of the study, a tentative coding framework was developed through reading of the FGDs and KII transcripts as well as the topic guides used to collect the data to generate a thematic framework to guide coding and the analysis. A final thematic framework was then developed after review of the data and the research question. It is this thematic framework that was then used for the initial coding before more themes were developed in the course of coding.

PART III: TB IN KENYA

Key drivers of TB in Kenya

The *TB Prevalence Survey* results (2015-2016) indicate that the prevalence in Kenya is 558 (455-662) per 100,000 adult population is higher than previously assumed. TB is known to have a strong association with poverty.[15] *The Global Fund*[16] notes that TB is a disease associated with poverty and social inequality that particularly affects vulnerable populations with poor access to basic services, those living in substandard housing and poor sanitation conditions, as well as populations in prisons and other closed settings. The World Health Organisation (WHO) estimates that people with TB experience a 30% decline in productivity during the course of the disease.

In Kenya, the *TB Prevalence Survey* results indicates that the highest burden of TB is in the economically productive age groups of 45-54 and 25-34, with a prevalence of 607 per 100,000 and 716 per 100,000 respectively. This underscores the negative economic effects of TB disease on households. During treatment, direct costs are incurred when patients have to travel to get medication or for treatment follow up. Food, accommodation, and drug administration also contribute to direct costs.

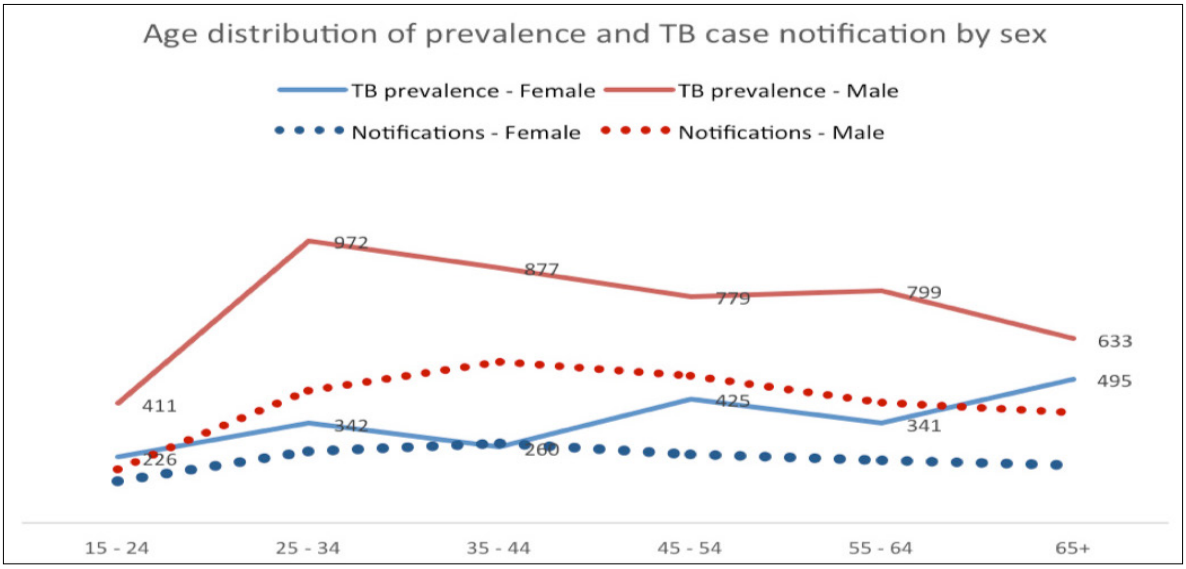

Figure 5 Age distribution of prevalence and TB case notification by sex

Crowded and poorly ventilated living and working environments often associated with poverty constitute direct risk factors for TB transmission. Poverty is also associated with inadequate access to information and lack of empowerment to act on health-related matters leading to increased risk of exposure to TB. Over half of the TB patients are malnourished to some degree at the onset of treatment, with 17% being severely malnourished and a further 22% being moderately malnourished. Malnutrition and hunger increases susceptibility to infection and fast progression of TB diseases. It is also a contributing factor in non-adherence to TB treatment.

15 WHO (2005) *Addressing Poverty in TB Control Guidelines*

16 Global Fund Information Note: Human Rights for HIV, TB, Malaria and HSS Grants (February 2014)

3.2. TB Key Populations

The Global Fund[17] defines Key populations for TB as people who are vulnerable, underserved or at-risk of TB infection and illness, and include people with increased exposure to TB due to where they live or work, people with limited access to quality TB services, and people at greater risk due to biological or behavioural factors.

Further, these groups are disproportionately affected by the disease, stigma and discrimination and human rights and gender-related barriers. They include: prisoners, miners, hospital visitors, health care workers, community health workers, migrant workers, women in settings with gender disparity, children, refugees, or internally displaced people, indigenous persons, illegal miners, migrants and people at increased risk of TB because of biological or behavioural factors that compromise immune function, for example PLHIV and Injecting Drug Users.

Kenya National Strategic Plan on Tuberculosis, Leprosy and Lung Diseases (2015–2018) recognizes that there are groups hosting disproportionately high rates of TB and/or being underserved by health services. These include urban slums, health care workers, mobile/migrant populations, refugees, prisoners, uniformed service personnel, PLHIV, contacts of TB patients, diabetics, and moderately and severely malnourished individuals. The recurrent prevalence of TB in Kenya has been occasioned by the low levels of TB awareness, TB-HIV co-infection, poverty, stigma, lack of access to quality health services and congestion in the country's correctional facilities.[18]

3.3. TB and HIV in Kenya

WHO reports that people who are infected with HIV are 20 to 30 times more likely to develop active TB.[19] At least a third of people living with HIV worldwide in 2015 were infected with TB bacteria. It therefore suffices that TB and HIV together form a lethal combination, each speeding the other's progress towards death of thousands. Kenya is ranked among the countries with a high TB burden. HIV/AIDS continues to be a key driver of the TB epidemic in Kenya with approximately 37% of patients with TB also living with HIV.[20]

The WHO country analysis for Kenya for the year 2015 indicated that there was 33% newly enrolled HIV positive persons on TB care and preventive treatment.[21] The report also indicated that mortality for TB-HIV only was 16 per 100000 persons. These are alarming figures that need immediate action to reverse the ordeal. With the fact that over 95 per cent of cases and deaths as a result of TB are in developing countries, Kenya is definitely in the red zone to ensure a proper roll-out programme to combat both the HIV and TB menace in the country (WHO 2016).

17 The Global Fund (2016) *Tuberculosis Information Note*
18 Susan Gacheri (2013) Eliminating catastrophic burden on Tuberculosis
19 WHO Tuberculosis Factsheet 2017 at http://www.who.int/mediacentre/factsheets/fs104/en/
20 Kenya National Strategic Plan on Tuberculosis, Leprosy and Lung Diseases 2015 – 2018
21 Kenya National Strategic Plan on Tuberculosis, Leprosy and Lung Diseases 2015 – 2018

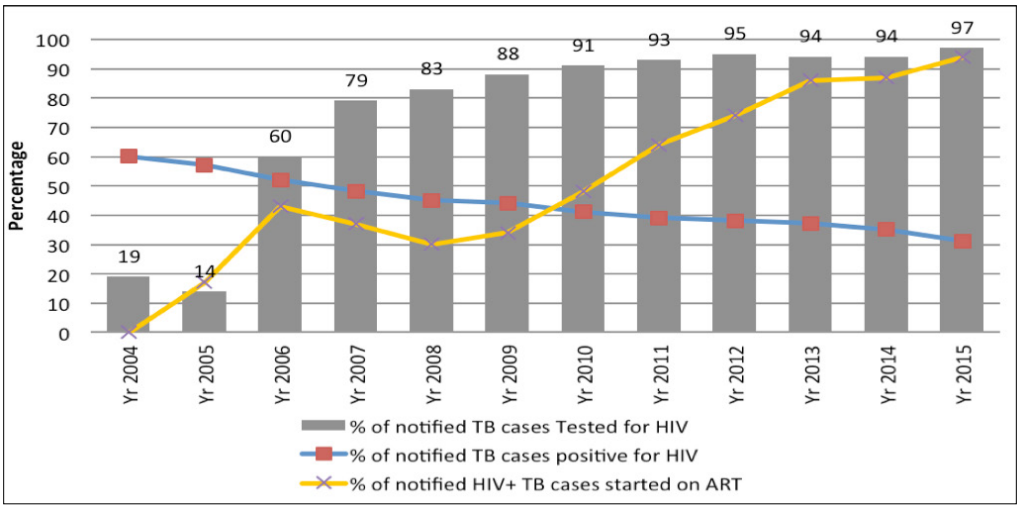

Figure 6: TB HIV trends in Kenya, 2004-2015

3.4. Challenges in TB prevention and control

Some of the challenges identified in addressing the TB epidemic in Kenya include:

- Inadequate resources to treat and prevent TB: Even though the Government of Kenya caters for TB treatment, it only funds about 28 per cent[22] while the rest of the funding is generated from donors. Relatedly, there are reported cases of misappropriation and mismanagement of funds meant for delivery of health care services in Kenya.[23]
- HIV/TB co-infection: Kenya has both a high prevalence and incidence rate of HIV and TB, creating dual epidemic.
- Resistant strains: According to the National TB, Leprosy and Lung Disease Unit (NTLD-U), Kenya had an estimated 234 multi-drug resistant tuberculosis patients (MDR-TB) in 2013, a TB strain that is resistant to both rifampicin and isoniazid. However, WHO estimated the number to be 2750 MDR cases in Kenya in 2013.
- Inadequate medical facilities: Control and treatment of TB requires availability of proper medical facilities equipped with the latest technology and trained. This is still a challenge and contributes to delayed diagnostic and treatment of TB.
- Low levels of TB awareness: There is limited public knowledge on TB prevention, care and treatment with some people having no knowledge of the signs and symptoms of TB.
- Frequent drug stock outs occasioned by financial constraints, mismanagement, and poor supply chain management, among other reasons.[24] There is need to ensure a stable supply of quality drugs.

22 Kenya National Strategic Plan on Tuberculosis, Leprosy and Lung Diseases 2015 – 2018

23 See "Civil Society Organizations demand for information from ministry of health on audit reports," at http://www.kelinkenya.org/2016/11/civil-society-organizations-demand-information-ministry-health-audit-reports/

24 See *TB Drugs in Kenya: A Grassroots Advocacy Success Story* available at https://www.results.org.uk/blog/tb-drugs-kenya-grassroots-advocacy-success-story (accessed November 13, 2017).

PART IV: LEGAL AND POLICY FRAMEWORK

4.1. International and regional legal and policy framework

TB approaches and responses at the international level are anchored in international and regional human rights instruments. These laws recognize that all human beings have equal rights regardless of their nationality, ethnic origin, sex, race, religion, or any other status and are built around core human rights principles.

By virtue of Article 2 (6) of the Constitution of Kenya, international instruments that Kenya has ratified form part of the Laws of Kenya. These international instruments provide a sound framework and basis for holding the government accountable where gaps exist at the domestic level.

Some of the relevant rights, as contained in various international legislative instruments, that closely affect the TB response, and should be relied upon in the protection of TB patients, include:

1. **Right to Life:** The argument is that people with TB have the right to access lifesaving diagnostics and treatment. In the event that such treatment is denied then the right to life is threatened. In Kenya, the practice of incarceration of TB patients (that was declared unconstitutional and unlawful) potentially infringed on this right where the required medical attention is not given while in prison. The right to life is defined internationally by the International Covenant on Civil and Political Rights (ICCPR) (Article 6(1).

2. **Right to the highest attainable standard of health:** People with TB have the right to enjoy the highest attainable standard of health encompassing availability, acceptability, accessibility and quality of diagnostics and treatment.The right imposes an obligation on governments to prevent, treat, and control epidemic, endemic, occupational and other diseases. It is defined by Article 12(1) of International Covenant on Economic, Social and Cultural Rights (ICESCR).

3. **Right to Non-Discrimination and Equality:** This right provides a framework for equal protection before the law. Therefore, this right protects persons with TB from discrimination in both public and private settings, including but not limited to, health care, employment, education and access to social services. This may also be relied upon to address the issues of stigma and discrimination. It is defined by International Covenant on Civil and Political Rights ICCPR (Article 26), Convention on the Rights of People with Disabilities (CRPD) (Article 5(2)), and International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) (Article 5(e)(iv))

4. **Right to privacy:** This is critical in the protection of information related to an individual's TB status, and privacy in treatment of TB patients. The right is exercised considering a delicate balance of individual rights versus protection of the public interest. The right is provided for under ICCPR (Article 17(1)).

5. **Right to be free from torture or cruel, inhuman or degrading treatment or punishment:** This right is specifically relevant for persons with TB in an institutional setting such as hospital, prison or isolation facility and would be relied upon to ensure there is appropriate TB testing, treatment, and good sanitary and hygienic conditions. It is defined by the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment CAT (Article 16(1)).

6. **Right to informed consent prior to treatment** of persons, including those with TB, and to be free from non-consensual, compulsory treatment under all circumstances.

7. **Right to freedom of movement that would protect people with TB from travel restrictions** within and outside their countries. It is provided for by Article 12 of ICCPR.

8. **Right to information that would guarantee persons with TB the right to access information** about the nature of the disease, preventive measures, transmission and treatment. This is as provided by ICCPR Art. 19(2); and WHO Guidance on Ethics of TB prevention, care and control.

9. **Right to freedom from arbitrary arrest and detention that is relied upon to protect persons** with TB against arbitrary detention or involuntary isolation unless as provided by law – and respecting the Siracusa Principles. The United Nations Economic and Social Council has issued Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights (the Siracusa Principles), which are the leading international framework for determining whether involuntary confinement for public health purposes is justified under the International Covenant on Civil and Political Rights (to which Kenya is a State Party). They provide that involuntary confinement for public health purposes will be legitimate only where:

- The restriction is provided for and carried out in accordance with the law;
- The restriction is in the interest of a legitimate objective of general interest;
- The restriction is strictly necessary in a democratic society to achieve the objective;
- There are no less intrusive and restrictive means available to reach the same objective; and
- The restriction is based on scientific evidence and not drafted or imposed arbitrarily or in an unreasonable or otherwise discriminatory manner.

The African Charter on Human and Peoples' Rights is important at the regional level. Article 16 of the African Charter on Human and Peoples' Rights provides:

1. Every individual shall have the right to enjoy the best attainable state of physical and mental health.

2. State Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

4.2. Domestic Legal and Policy Framework

4.2.1. The Constitution of Kenya

The Constitution is the supreme law of the Republic and binds all persons and all State organs at both levels of government. It sets out the standards that all laws, policies, guidelines, operational standards and programs must conform with.

The Constitution of Kenya has an expansive and progressive Bill of Rights that sets out the stage for the promotion and protection of the rights of all persons, persons with TB included.

- Importance of Bill of Rights
- The importance of the bill of rights cannot be understated. Article 19 (1) provides that the Bill of Rights is an integral part of Kenya's democratic state and is the framework for social, economic and cultural policies. The rights and fundamental freedoms in the Bill of Rights further belong to each individual and are not granted by the State [(19(3)(a)].
- Health a devolved function

- It is important to appreciate that the Constitution creates a devolved system of governance, with government divided into two levels, national and county level. This is as provided under Article 6 that also requires the two levels of government to conduct their mutual relations on the basis of consultation and cooperation.

Devolution is important in understanding the context within which health services are delivered in Kenya. The fourth schedule to the Constitution bestows upon county governments the responsibility of delivering health services (TB services include), with the national government being responsible for setting of standards and management of national referral facilities.

Article 10 Principles

- Article 10 of the Constitution outlines the national values and principles of governance that are binding to state organs, state officers, public officers and all persons whenever they *apply or interpret the Constitution*; *enact, apply or interpret any law*; or *make or implement public policy decisions.*
- The national values and principles of governance include: *human dignity, equity, social justice, inclusiveness, equality, human rights, non-discrimination and protection of the marginalized,* among others. Article 10 is particularly important to the TB response as it provides guidance in relation to formulation and implementation of laws, policies, and strategies on TB prevention and management. TB strategies in Kenya must be formulated and implemented in a manner that respects the national values, especially through ensuring the participation of TB affected communities.

TB-related human rights

- Chapter Four of the Constitution outlines the rights and fundamental freedoms that belong to each individual. The State is charged with the responsibility to *observe, respect, protect, promote and fulfil* the rights and freedoms contained in the Bill of Rights.
- The most prominent provision of the Constitution in the TB response is Article 43 that guarantees the right to the highest attainable standard of health. The State is under an obligation to take legislative, policy and other measures, including the setting of standards, to achieve the progressive realization of the right to health.

4.2.2. Health Act 2017

The Health Act 2017 was enacted primarily to align the health sector to the Constitution. The Act aims to:

- Establish a national health system that facilitate in a progressive and equitable manner the highest attainable standard of health services;
- Protect, respect, promote and fulfil the health rights of all persons in Kenya including rights of children to basic nutrition and health care services, and rights of vulnerable groups as defined in Article 21(3) of the Constitution.[25]

The Act is important in the TB response as it affirms the Constitutional duty of the State to observe, respect, protect, promote and fulfil the right to the highest attainable standard of health. The Act further provides that the right to heath includes:

(i) progressive access for provision of promotive, preventive, curative, palliative and rehabilitative services;
(ii) right to be treated with dignity, respect and have their privacy respected;
(iii) right to health information;
(iv) right to informed consent;
(v) right to privacy and confidentiality, among others.

25 Article 21 (3) provides: *All State organs and all public officers have the duty to address the needs of vulnerable groups within society, including women, older members of society, persons with disabilities, children, youth, members of minority or marginalised communities, and members of particular ethnic, religious or cultural communities.*

Health providers on the other hand have, among other rights, the right to a safe working environment that minimizes the risk of disease transmission. This is important in protection of Health Care Workers in the TB response.

The affirmation of the rights in this Act makes it fairly progressive.

4.2.3. The Public Health Act (Cap 242 Laws of Kenya)

The Public Health Act makes provision for securing and maintaining health and governs the way services are delivered in health facilities. The Act contains specific provisions on TB, which is classified as a notifiable infectious disease.

Part III of the Act contains provisions on notification of infectious diseases. Section 17 classifies *all forms of tuberculosis which are clinically recognized apart from reaction to the tuberculin test* as one of the notifiable infectious disease.

Section 18 proceeds to impose an obligation on family members, medical practitioners, or any other person in charge of a TB patient to notify the Director of Medical Services of this patient.

The section makes it a criminal offence if one does not notify the relevant authority. One may be liable to a fine not exceeding eighty (80) shillings.

Whereas the intention of this provision may be to protect the public, there needs to be clear guidelines on how this should be done in order to protect the privacy, confidentiality and respect the human rights of the patient. The punitive nature of this provision may also not serve its intended purpose but rather cause fear, exacerbate stigma and discrimination and make society view TB patients as 'criminals' 'misfits' or 'outcasts.'

Part IV of the Act contains provisions on prevention and suppression of infectious diseases. This part provides for isolation of persons with infectious diseases, including involuntary isolation.

Section 27 provides:

> Where, in the opinion of the medical officer of health, any person has recently been exposed to the infection, and may be in the incubation stage, of any notifiable infectious disease and is not accommodated in such manner as adequately to guard against the spread of the disease, such person may, on a certificate signed by the medical officer of health, be removed, by order of a magistrate and at the cost of the local authority of the district where such person is found, to a place of isolation and there detained until, in the opinion of the medical officer of health, he is free from infection or able to be discharged without danger to the public health, or until the magistrate cancels the order.

Section 28 of the act provides:

> *Any person who—*
> *(a) while suffering from any infectious disease, willfully exposes himself without proper precautions against spreading the said disease in any street, public place, shop, inn or public conveyance, or enters any public conveyance without previously notifying the owner, conductor or driver thereof that he is so suffering; or*
> *(b) being in charge of any person so suffering, so exposes such sufferer; or*

(c) gives, lends, sells, transmits or exposes, without previous disinfection, any bedding, clothing, rags or other things which have been exposed to infection from any such disease, shall be guilty of an offence and liable to a fine not exceeding thirty thousand shillings or to imprisonment for a term not exceeding three years or to both; and a person who, while suffering from any such disease, enters any public conveyance without previously notifying the owner or driver that he is so suffering shall in addition be ordered by the court to pay such owner and driver the amount of any loss and expenses they may incur in carrying into effect the provisions of this Act with respect to disinfection of the conveyance: Provided that no proceedings under this section shall be taken against persons transmitting with proper precautions any bedding, clothing, rags or other things for the purpose of having the same disinfected.

Section 27 of the Public Health Act gives the public health officer the authority to remove and request for the isolation of persons who have been exposed to infection or may be in the incubation stage of an infectious disease while section 28 provides for the penalty for exposure to infectious substance. These two sections have been used to incarcerate TB patients for "failure to adhere" to TB treatment. The patients would be arraigned in court and convicted for up to seven or eight months, or until the satisfactory completion of their TB treatment.

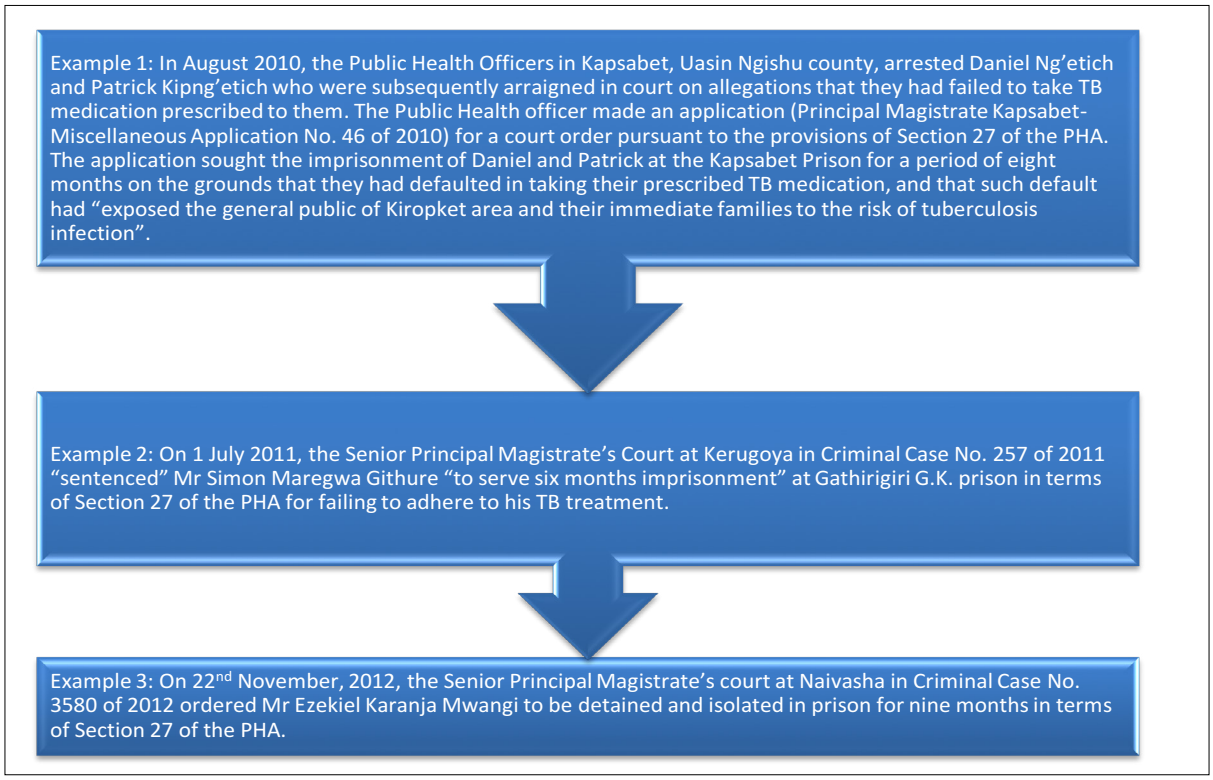

Figure 7: Examples of cases where Public Health Act has been used to jail TB Patients

It is this widespread practice of imprisonment of TB patients that made KELIN to file a constitutional petition (Petition 329 of 2014). This was filed to challenge the unlawful and unconstitutional incarceration of TB Patients. KELIN argued that the manner and conditions of the incarceration endangered the health of the patients and prison population. Prison conditions, being overcrowded and congested, are ideal for the rapid transmission of TB, thereby endangering the prisoners and the general public. Further, the Kenyan prisons do not have isolation or medical facilities where proper care and treatment of TB patients can be provided.

In a judgment delivered on 24 March 2016, the High Court of Kenya declared that the practice of confining patients suffering from TB in prison facilities for the purposes of treatment under section 27 of the Public Health Act a violation of the Constitution and unlawful.

The Court ordered the Government to issue a circular to public health officers to the effect that section 27 should not be used to confine TB patients in prisons. The Government was also directed to commence the process of developing a policy on involuntary confinement of persons suffering from infectious diseases (TB included) and that this policy should be in line with international standards.

TB Activists outside the Milimani Law Court during the hearing of petition 329 of 2014 (TB is not a crime case)

4.2.4. Laws on prisons settings

Prisons Act (Cap 90 Laws of Kenya)

TB is a major public health concern in prisons. Congestion and overcrowding in prisons exacerbates the spread of TB, thereby placing prisoners among populations at an increased risk of contracting TB. The World Health Organization (WHO) notes: "most prisons inmates are faced with elevated risk factors for acquiring TB, such as crowded and poorly ventilated spaces, inadequate prevention, medical care and treatment, stress and malnutrition."[26] The National Tuberculosis, Leprosy and Lung Disease Program identifies prisoners as populations at high-risk to TB. In its Strategic Plan the TB Program notes that[27].

26 See WHO (2017 *Ethics guidance for the implementation of the End TB strategy,* pg 29, available at http://apps.who.int/iris/bitstream/10665/254820/1/9789241512114-eng.pdf (accessed 9 Nov 2017).

27 See Kenya National Strategic Plan on Tuberculosis, Leprosy and Lung Diseases 2015 – 2018, pg 23.

"TB case notification rates in two large prisons in Kenya, Meru and Embu, were 941 and 4,714/100,000 respectively in 2012. These rates are 4-10 times higher than in the surrounding population. It is estimated that similarly disproportionately high rates occur in other prison settings."

The Prisons Act (Cap 90) makes provisions on prisons in Kenya. Section 29 requires that medical officers be stationed in or responsible for every prison, and responsible for the health of all prisoners. The prison medical officer may, whether or not a prisoner consents, take such action (including forcible treatment of the prisoner) as he may consider necessary to safeguard or restore the health of the prisoner or to prevent the spread of a disease.

The Act does not make provisions for regular screening, voluntary screening of prisoners, including TB screening. Section 29 of the Prisons Act that allows for forcible treatment needs to be reviewed to ensure that rights to informed consent, privacy and confidentiality are protected when providing medical services to prisoners. Moreover, the Prison Act needs to be reviewed for integration of rights-approaches especially proclamation of rights that prisoners should be accorded.

The Act also fails to provide guidance on general issues of a prison setting that have public health consequences, for example, addressing congestion, adequate ventilation, sanitation, and related issues.

Persons Deprived of Liberty (Act No. 23 of 2014)

This Act was enacted to give effect to Article 29(f) and 51 of the Constitution. Article 29(f) provides that *every person has the right to freedom and security of the person, which includes the right not to be treated or punished in a cruel, inhuman or degrading manner*. Article 51 on the other hand outlines rights of persons detained, held in custody or imprisoned. The Act defines a *person deprived of liberty* as a person who has been arrested, held in lawful custody, detained, or imprisoned in execution of a lawful sentence.

This Act is fairly progressive and aligned to the Constitution. It makes provision for the right to health care for all persons detained, held in custody or imprisoned which include medical examination, treatment and healthcare, including preventive healthcare.[28] Proper implementation of this Act will positively impact on the TB response through ensuring that all persons detained, imprisoned, or held in custody have access to health services.

The Act makes provisions for confidentiality of health information of persons deprived of liberty.29 It allows for disclosure of health information of a person deprived of liberty which relates to infectious or communicable diseases in order to facilitate effective health care for that person and facilitate the protection of other persons deprived of liberty and the officers under whose charge such persons are accommodated.30 However, there is need to develop guidelines for this disclosure to ensure that it is implemented in a manner that respects rights to privacy and confidentiality, and does not lead to stigma, discrimination and violence.

4.2.5. Employment Act (Chapter 226)

This Act declares and defines fundamental rights of employees. Section 5(3) outlaws discrimination against an employee on grounds of race, colour, sex, language, religion, political or other opinion, nationality, ethnic or social origin, disability, pregnancy, mental status or HIV status. This Section, read together with Article 27(4) of the Constitution, would be relied upon to protect a person with TB against any discriminatory acts in an employment setting and at the workplace.

Section 30 of the Act allows an employee to take sick leave which (in addition to other leave entitlements).

28 Section 15 Persons Deprived of Liberty Act.
29 Section 16 (1) Persons Deprived of Liberty Act.
30 Section 16 (2) Persons Deprived of Liberty Act.

It provides: *After two consecutive months of service with his employer, an employee shall be entitled to sick leave of not less than seven days with full pay and thereafter to sick leave of seven days with half pay, in each period of twelve consecutive months of service, subject to production by the employee of a certificate of incapacity to work signed by a duly qualified medical practitioner or a person acting on the practitioner's behalf in charge of a dispensary or medical aid centre.*

Section 34 makes provisions for medical attention. It provides that *an employer shall ensure the sufficient provision of proper medicine for his employees during illness and if possible, medical attendance during serious illness.* Further, that an *employer shall take all reasonable steps to ensure that he is notified of the illness of an employee as soon as reasonably practicable after the first occurrence of the illness.*

The Act also protects employees against unfair termination and obliges employers to give written notice for termination of employment. However, a contract for daily wages can be terminated by either party at close of any day without notice. This affects TB patients who are casual labourers since they risk losing their job as they access their daily medication.

The Employment Act could be relied upon to protect rights of TB patients in employment and to ensure that they are not discriminated against, have access to medical attention, and for protection of their jobs. However, the Act needs to specifically provide for the right to access medical services and give guidance on sick leave for casual labourers. In the context of TB, this greater protection is necessary given that most casual labourers reside at informal and congested settlements hence at a higher risk of contracting TB.

4.2.6. Children Act (No. 8 of 2001)

According to the World Health Organization, an estimated 1 million children became ill with TB in 2016 and 250 000 children died of TB (including children with HIV associated TB).[31]

The Children Act protects the right of children including the right to health and medical care. The Act also outlaws discrimination of children on any ground including origin, sex, religion, creed, custom, language, opinion, conscience, colour, birth, social, political, economic or other status, race, disability, tribe, residence or local connection.

The principle of the best interest of the child, as contained in this Act and the Constitution, is important in protecting children including those affected by TB. Article 53 of the Constitution provides that every child has the right to basic nutrition, shelter and *health care*; and that a child's best interests are of paramount importance in every matter concerning the child. This is also provided for in Section 4(2) of the Children Act.

4.2.7. Policies, strategies and guidelines

Kenya Health Policy (2014 – 2030)

In 2014, Kenya developed a national health policy to align the heath sector to the Constitution of Kenya 2010.

The goal of the Policy is "to attain the highest possible standard of health in a responsive manner." This would be achieved by supporting equitable, affordable, and high-quality health and related services at the highest attainable standards for all Kenyans. The policy sets out as one of its objectives the elimination of communicable conditions and recognizes the fact that tuberculosis has resurfaced as a major cause of ill health.

31 World Health Organisation Fact Sheet *Tuberculosis* available at http://www.who.int/mediacentre/factsheets/fs104/en/ (accessed November 13, 2017).

The policy thus sets the target for *a significant reduction in the general ill health in the Kenyan population by achieving reductions in deaths due to communicable diseases by at least 48 per cent.*

The Policy provides direction on delivering the progressive realization of the right to health.

It provides: *The national and county governments will put in place measures to progressively realize the right to health as outlined in Article 21 of the Constitution. The sector will employ a human rights-based approach in health care delivery and will integrate human rights norms and principles in the design, implementation, monitoring, and evaluation of health interventions and programmes. This includes human dignity; attention to the needs and rights of all, with special emphasis on children, persons with disabilities, youth, minorities and marginalised groups, and older members of the society (Constitution of Kenya 2010, Article 53–57); and ensuring that health services are made accessible to all.*

This policy provides an important framework for the implementation of health programmes in Kenya, TB included. It provides a good persuasive authority to protect the rights of persons with TB and in holding the government accountable on its commitments. National Patients' Rights Charter (2013) The National Patients' Rights Charter, launched in 2013, was informed by the need for patients in Kenya to be aware of their rights and responsibilities. It enumerates the rights of patients, including, the right to access to health care, the highest attainable standard of health services, the right to information, right to informed consent, and right to confidentiality, among others.

It provides guidance on rights and responsibilities of patients and would be critical in expounding on Constitutional rights. It is useful in protection of the rights of TB patients in a health care setting as most of the rights contained therein are in line with the Constitution and International Framework.

Kenya National Strategic Plan on Tuberculosis, Leprosy and Lung Diseases 2015 – 2018

The 2015-2018 Strategic plan aims to *accelerate the reduction of TB, Leprosy and lung disease burden through provision of people-centered, universally accessible, acceptable and affordable quality services in Kenya.*

The Strategic plan recognizes that human *rights based approach in the case of TB, leprosy and lung diseases would involve integrating human rights principles in the design, implementation, monitoring and evaluation of TB, leprosy and lung diseases programs.*

The Strategic Plan has a chapter on gender and human rights and appreciates that *"Key vulnerable groups in the context of TB, leprosy and lung diseases are more likely to be exposed to conditions that are conducive to TB, leprosy and lung diseases development, and less likely to have the information, power and resources necessary to ensure their access to health services. The stigma and discrimination associated with TB, leprosy and lung diseases, and the overlapping discrimination based on gender, poverty, or HIV status, can affect people's employment, housing and access to social services. Gender inequalities can impact health risks, health seeking behavior and responses from health systems, leading to poorer outcomes for everyone. It is thus important to address the different needs of women and men, girls and boys taking into account their diversity. This may involve undertaking gender responsive programming where one takes into account the prevailing gender norms or undertaking gender transformative programming, where one seeks to change harmful gender norms that act as a barrier to accessing health services."*

National Guidelines on Management of Tuberculosis in Children (2016)

These Guidelines seek to provide guidance to health care workers in managing paediatric TB. It is an important guideline especially given the challenges of diagnosis and treatment of TB in children.

One provision in the Guidelines requires that a*ll TB patients must be tested for HIV, and all efforts must be made to classify them either as HIV positive or HIV negative as this impacts management.* Whereas this may be necessary in the proper management of TB, caution must be taken to ensure that such provisions do not infringe on the rights to informed consent, privacy, and confidentiality. The Guideline further provides important strategies for management of patients to prevent TB transmission, including:

- cough monitoring at facility and community levels;
- education on cough hygiene;
- provision of masks/tissues to coughing clients as they enter the facility;
- separation of clients who cough from those who don't;
- reduction of waiting times for clients who cough;
- early referral and investigation of clients who are coughing for TB;
- provision of a safe environment for collection of sputum;
- reducing exposure in the laboratory;
- isolation; and
- surveillance for TB disease/infection among health care workers.

Guidelines for TB infection Prevention and Control for Health Care workers in Kenya 2014

These guidelines were developed given the fact that health care workers are at increased risk of TB infection and disease compared to the general population. The guidelines note that other patients, non-medical staffs in health care settings are also at risk. Health care settings present risk of TB transmission from those who are undiagnosed pulmonary TB patients with a cough who are in close contact with patients and health care workers. It recognizes that overcrowding and poorly ventilated environments increase this risk and that waiting rooms or corridors where patients wait to receive medical care are areas of particular risk.

The Guideline requires the use of administrative control measures to ensure early recognition of presumptive TB patients or patients who have confirmed TB disease, rapid diagnostic investigation of presumptive TB patients, separation of potentially infectious TB patients/presumptive TB from other patients, and prompt initiation of appropriate TB treatment. It also provides for additional measures such as isolation of multidrug-resistant TB (MDR-TB) or extensively drug-resistant TB (MDR-TB).

Guidelines for management of Tuberculosis and Leprosy in Kenya (2013)

This guideline is a revision of the earlier versions produced in 1994, 2000, 2003, 2008 and 2009. The guideline makes provision for TB management, control and prevention, and provides direction on management of drug resistant TB.

It provides that: *In ideal setting patients who are smear or culture positive for MDR-TB should be treated in isolation facility. An isolation facility should meet all infection control measures as per WHO and national guidelines. Patients who have converted can be treated on an ambulatory basis or through home based care and observing infection control measures. In case there are not enough isolation beds, the isolation facility should prioritize patients who need admission due to side effects to the DRTB drugs.*

These guidelines do not seem to distinguish between voluntary and involuntary isolation. Meaningful voluntary isolation is encouraged, with use of less restrictive means such as use of masks first, before involuntary isolation is considered. Instead of assuming that involuntary isolation is appropriate, health workers should make an assessment of the least invasive/restrictive approach for the patient, including counseling, and in line with WHO recommendations and guidance on involuntary isolation.

(i) MOH/ADM/1/1/2 Policy Directive of 12 May 2016 on the Imprisonment of TB Patients

This Circular of 12 May 2016, gives a policy direction to County Members of Health, Chief Officers of health, and County Directors of health to immediately implement the High Court judgment on the imprisonment of TB patients directing that the confinement of TB patients for treatment purposes should not be done in prison facilities and that where such confinement is found to be necessary, court orders should be sought for isolation in health facilities in a manner that protects the patients as well as the public interest. The ministry has also initiated plans to develop a broader policy on the issue of isolation.

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When replying please quote:

Ref: MOH/ADM/1/1/2

Date: 12 May 2016

County Executive Committee Members for Health
Chief Officers of Health
County Directors of Health

Thro:

The Chairman
Council of Governors
Delta Plaza
Westlands

RE: IMPLEMENTATION OF THE HIGH COURT JUDGEMENT CHALLENGING THE IMPRISONMENT OF TB PATIENTS

Following the High Court ruling issued on March 24th 2016 that found the confinement of TB patients in prisons unlawful and unconstitutional, the following measures are to be applied with immediate effect:

1. Confinement of patients suffering from infectious diseases for the purposes of treatment shall not be done in prison facilities
2. Where despite all reasonable efforts, patients with infectious disease are unwilling or unable to comply with treatment; court orders shall be sought to compel isolation, confinement or detention as referred to in section 27 of the Public Health Act, CAP 242
3. The isolation can be done at a health facility in adherence to; infection control measures and for the purpose of ensuring that patients adhere to the course of treatment for the public interest and their own interest
4. The Ministry of Health in consultation with county governments, shall in due course issue further policy direction on the involuntary confinement of persons with TB and other infectious diseases.

Dr. Nicholas Muraguri
PRINCIPAL SECRETARY

(ii) MOH/ADM/1/1/2 – Operational guidelines for Isoniazid Preventive Therapy (IPT) for PLHIV – 10 September 2015

This Circular was issued to provide guidance for IPT use for PLHIV. A particular point to note from the circular is the categories of clients eligible for IPT. One of its provisions requires that *prisoners who screen negative for active TB (irrespective of their HIV status) are eligible for IPT.* This is an important requirement in addressing the problem of TB in prisons. This policy directive remains largely unimplemented in prisons.

Guidelines on school infrastructure: Safety Standards Manual for Schools in Kenya

The safety standards manual for schools in Kenya provide *the corridors and classrooms should be both well ventilated and lit.* The guidelines also provide for measures *such as isolation, quarantine and vaccination, to protect those not yet infected from those who already show symptoms of infections of contagious diseases such as mumps, measles and tuberculosis.* Further, that *a mechanism, such as regular medical check-ups of learners, be put in place for early detection and management of infectious diseases/outbreaks.*

However, the practice largely fails to adhere to the guidelines. Relatedly, violation of rights of students with TB is a common factor where isolation is interpreted to mean 'denial of chance to attend classes.' This demonstrates the lack of information on TB, especially when this happens at a period when one is not infectious. There is thus need for the guidelines to incorporate direction on handling school going children suspected of having TB. This will guard against possible violation of right to education.

PART V: FIELD RESEARCH FINDINGS

5.1. Introduction

This section reports information gathered through key informant interviews, a focus group discussion and a community multi-stakeholder dialogue forum. It reports responses of fourteen key informants including the National TB Programme, County TB Coordinators, Health Care workers of health care workers, civil society organization, former TB patients, among others.

Further, this section also provides a summary of issues that emerged during an inter-county multi-stakeholder dialogue held in Kisumu County. The dialogue was attended by at least 45 participants representing communities of TB survivors, health care workers, law enforcement officers, civil society organizations, research organizations, County TB coordinators, among others from the counties of Kakamega, Busia, Homa Bay and Kisumu. The field research utilized data collection tools tailored for each category of respondents (see Annexure II).

5.2. TB in Kenya

Respondents reported that the burden of TB in Kenya is higher than initially thought. The respondents made this affirmation and referred to the findings of *Tuberculosis Prevalence Survey 2015-2016.*[32] The survey report indicated that about 40% of TB cases go undiagnosed and untreated. According to the World Health Organisation, Kenya is still ranked among the 22 high TB burden countries.[33] Respondents who took part in this study expressed concern that the mortality rate due to TB is high despite the fact that TB is a preventable and treatable disease.

32 Government of Kenya (GoK) (2017) *Kenya Tuberculosis Prevalence Survey 2015-2016 Assessing Kenya's TB Burden*

33 See WHO 2016 estimates at https://extranet.who.int/sree/Reports?op=Replet&name=/WHO_HQ_Reports/G2/PROD/EXT/TBCountryProfile&ISO2=KE&outtype=PDF

The following were generally identified by the respondents as populations at an increased risk of contracting TB in Kenya:

(a) People in prisons or in remand mainly due to overcrowding and poor ventilation in prisons and remands. Further, respondents identified poor screening, diagnosis and treatment of inmates as another contributory factor.

(b) People living in slums and informal settlements mainly due to the ease of transmission due to overcrowding. This population also has financial, geographical and social barriers to health care.

(c) Migrants and refugees who face challenges in accessing health care services. Social determinants arising from migration, such as living in cramped settlements, and income and food instability, also increase the risk of TB.[34]

(d) Drug users have poor health-seeking behaviour and challenges adhering to medication mainly because of drug addiction, social stigma and economic factors.

(e) Children and school going students are at an increased risk of contracting TB. Challenges in diagnosing TB among children delay detection and treatment of TB. School going children, especially in public institutions, are at increased risk due to congestion and overcrowding in the institutions.

(f) People living with HIV have reduced immunity and thus at increased risk. However, the *prevalence survey* in Kenya indicates that prevention efforts for PLHIV have largely been successful.

(g) Respondents identified males in urban settings as a group at increased risk of contracting TB based on the findings of the Prevalence Survey. The respondents suggested that this may be related to poor health-seeking behaviour, delays at health facilities and long hours spent at work.

(h) Health care workers who are in constant contact with TB patients are at increased risk due to their work.

The Respondents however noted that data on persons at increased risk of contracting TB is only available for people living with HIV. There is scanty information and almost no data available for the other TB key populations. Hence the respondents provided the above categories based on working experiences, findings of the prevalence survey and National TB programme reports.

Respondents also noted that TB in Kenya is exacerbated by factors that include inadequate TB screening at work places, schools, prisons, and in hospitals.

It was reported that the high TB burden has posed a great challenge and strain to the public health system. Consequently, some healthcare facilities lack the capacity to conduct both diagnosis and treatment and thus end up making referrals. Patients would thus incur extra travel expenses, delay in treatment and subsequent loss to follow up along the treatment cascade. This in itself contravenes the fundamental principles under Article 43(1)(a) of the Kenyan Constitution, as well as General Comment 14 of the ICESCR which obliges states to ensure that health care is available, affordable and most importantly accessible.

34 Kenya National Strategic Plan on Tuberculosis, Leprosy and Lung Diseases 2015 – 2018

The referrals have a negative consequence on persons with poor health seeking habits, for example drug users. However, health care workers reported that they make referral of TB patients to health facilities near the patient's place of residence for ease of access.

5.3. TB treatment

Respondents reported that although TB drugs are free in public health facilities, TB patients pay for some of the costs that are directly related to treatment. For example, TB patients reported paying for chest x-ray services, and for initial laboratory tests such as liver and kidney function tests. These costs are only waived for Multi Drug Resistant TB patients in the course of their treatment. The patients having to burden the out of pocket payments (OPP) may find it an impediment to properly treat their prevailing TB condition.

Respondents reported that most of the TB drugs available in Kenya are quality assured and WHO prequalified. The quality is further controlled by central procurement, distribution, and dispensation, in addition to adhering to procedures of Directly Observed Treatment short - course (DOTs). Notably, Kenya is resorting to shorter treatment regimens, from 9 months to 6 months for drug susceptible TB and from 24 months to 18 months for MDR-TB. However, the two new drugs bedaquiline and delamanid recently developed are still not accessible to patients in Kenya.

TB survivors and civil society respondents were however sceptical about the quality of drugs due to the reported side effects caused by the drugs. It was reported by the respondents that there is generally good quality diagnostic tools that are available at public health facilities, especially microscopy and GeneXpert. However, GeneXpert machines are few across the country despite being the recommended 1st line diagnostic tool hence posing a threat to timely diagnosis. Relatedly, there has been lack of implementation of TB LAM, a TB diagnostic tool specifically for PLHIV with low CD4 counts or very sick.

5.4. Harmful practices

Respondents identified practices, occasioned by legal or policy gaps, which exacerbate the risk of TB in certain populations. For example, respondents identified prison infrastructure which does not allow for adequate ventilation as contributing to the spread of TB in prisons. Respondents were of the view that both security and health concerns should be considered in the design of prison infrastructure.

Further, respondents cited the practice of arresting and jailing of TB patients that made TB patients afraid of seeking medical attention.[35] This has since been declared unconstitutional.

Relatedly, practices at the health facility level that promote seeking treatment at specific facilities may be unfavourable to migrants and mobile populations who have to undergo stringent procedures to access treatment in other facilities. 'Illegal immigrants' on the other hand feel insecure about being arrested if they leave the place of residence to access health care.

On the same breadth, 'casual' workers are greatly inconvenienced by the DOTs practice especially if there are delays at the health facility. Most of these casual employees work for long hours and may have limited time to visit a health facility. Improving community based care mechanisms could help address this issue. Access to services for populations in informal settlements is also a challenge. This is due to the fact that few health facilities serve a large population thus causing delays in service dispensation further discouraging people from seeking health services.

35 See Petition 329 of 2014 *Daniel Ng'etich & Others* v. Attorney General & others.

5.5. Treatment support

Health facilities in Kenya offer diagnosis for drug susceptible TB, treatment, referral services and some offer additional services including follow-up, counselling and nutrition support. Most of the facilities initiate DS-TB and DR-TB treatment and services. Patients with drug susceptible TB are supported to complete their treatment through DOTs and counselling. On the other hand, multi-drug resistant TB patients receive support from the government in form of free access to laboratory tests, travel support, clinical review and daily DOTs.

Health care workers reported that they currently provide counselling to TB patients. However, the high numbers of patients pose a challenge. Despite treatment support initiatives, treatment interruption is still persistent. Respondents attributed treatment interruption to reasons that include side effects of drugs; drug use; ignorance; delays at health facilities; shortages or stock outs especially the paediatric formulation.

5.6. Information dissemination

Dissemination of information on TB was identified as a challenge with most people still not having proper information on the modes of transmission of TB, sign and symptoms, infection control, treatment and management. Access to health education and information in relation to TB would normally be given by civil society organisations, and the TB programme during activities, and health education days. Health talks are given in most TB Treatment facilities and CCCs on TB treatment/clinic days, but this would only reach TB patients. The lack of proper information contributes to high stigma against people with TB, and may cause human rights violations.

5.7. Isolation of TB patients

Previously, isolation of TB patients who failed to adhere to their medication was through incarceration in prisons. This practice happened despite the fact that prisons did not have isolation wards, lacked ventilation and are highly congested. The High Court in the case of *Daniel Ng'etich & Others* v. *Attorney General & Others* declared the practice illegal and unconstitutional. The practice had for a long time been used to 'scare' TB patients to adhere to medication. In such instances, patients would be denied the right to proper information on TB treatment and management, the benefits of adherence and side effects of TB medication.

The court gave a directive that the government develops an isolation policy that complies with international standards and respects the rights of TB patients. Respondents reported that isolation is still a challenge. Without the isolation policy, facilities lack guidance on the standards of isolation wards, circumstances to enforce involuntary isolation, control measures, standards on specialized care, support, security, among other issues.

5.8. Rights-based approach to TB services

Respondents reported a rights-based approach is yet to be realized in the management, treatment, care and support of TB patients in Kenya. Despite the diagnosis and treatment of TB being free, patients still incur costs and suffer the pain of an ailing public health system characterized by delays in provision of services, negative attitude of health care workers, poor dissemination of information on TB, and a lack of involvement of communities of TB survivors in decision making processes.

The lack of guidance on isolation of patients, and the non-existence of isolation units is a loophole for possible human rights violations of TB patients. Further, there is hardly any guidance on addressing TB related discrimination and violation of human rights at the facility and policy level. Empowerment and education of patients on rights and about TB is largely left to community based, civil society and partner organizations.

5.9. TB & HIV integration

There exists a policy framework on TB and HIV integration. Services are integrated in most health facilities. However, respondents noted that this has not been actualised in most health care settings.

An alarm was sounded on HIV negative people, who now form a majority of the 'missing TB cases'. Respondents noted that this is because a lot of focus has been given to people living with HIV and the interventions have largely been successful. It was also reported that an HIV test is conducted on all patients seeking TB services which furthers stigma towards TB.

5.10. Enforcement of laws or policies on nondiscrimination

Article 27 of the Constitution guarantees the right to equality and non-discrimination. However, respondents reported practices of discrimination of persons with TB, and increased stigma mostly due to the perception that TB patients are also living with HIV, practice of involuntary isolation, and limited public information and education on TB. TB patients on the other hand are largely unaware of their rights hence prone to human rights violation especially discrimination at the workplace, in health facilities, schools, and other social settings.

The counseling process and the community health volunteers support that TB patients receive helps in ensuring adherence to medication. However, challenges related to stigma and discrimination would negatively impact such adherence. TB patients find it difficult to disclose that they have TB for fear of losing their jobs or being locked out of public and social spaces. Most patients who face discrimination do not report such violations. For example, there are instances where patients have lost their jobs due to TB disease and have been denied permission to seek TB heath care services. Such cases go unreported. This has led to other patients being afraid to disclose their TB status to their employers for fear of losing their jobs. Hence they suffer in silence. There have also been unreported cases of school going children being turned away from school when undergoing TB treatment (despite not being infectious).

Table 2: How the constitution of Kenya protects T B- Related Human Rights

No	Article	Summary	Relevance to TB
1	2 (4) Supremacy of the Constitution	Any law that is inconsistent with the Constitution in void.	This will help deal with laws that violate the rights of people with TB.
2	Article 2(6) Supremacy of the Constitution	Any treaty or law ratified by Kenya shall form part of the law	This will help in ensuring we set our TB standards in relation to International Instruments we have ratified. It provides a legal basis of holding the government accountable on international commitments relating to TB
3	Article 6 Devolution and access to services	Makes provisions for counties and devolution	This will help in the access to services specifically so in the context of TB. It also gives the basis under which Counties should take leadership in TB prevention, treatment, care and support.
4	Article 7(3)b National and Official Languages	Promotion of use of indigenous language, Kenyan Sign language, Braille and other Communication formats accessible to persons with disabilities	This will help with ensuring and providing an adequate framework for Persons with Disability and people from indigenous community to have access to TB related information
5	10 (1) National Values and Principles of Governance	Sets out the national values and principles to govern state organs and officers, these include principles such as human dignity and non discrimination	This helps to lay a basis on which all state officers, including health care workers, working on matters relating to TB are expected work.

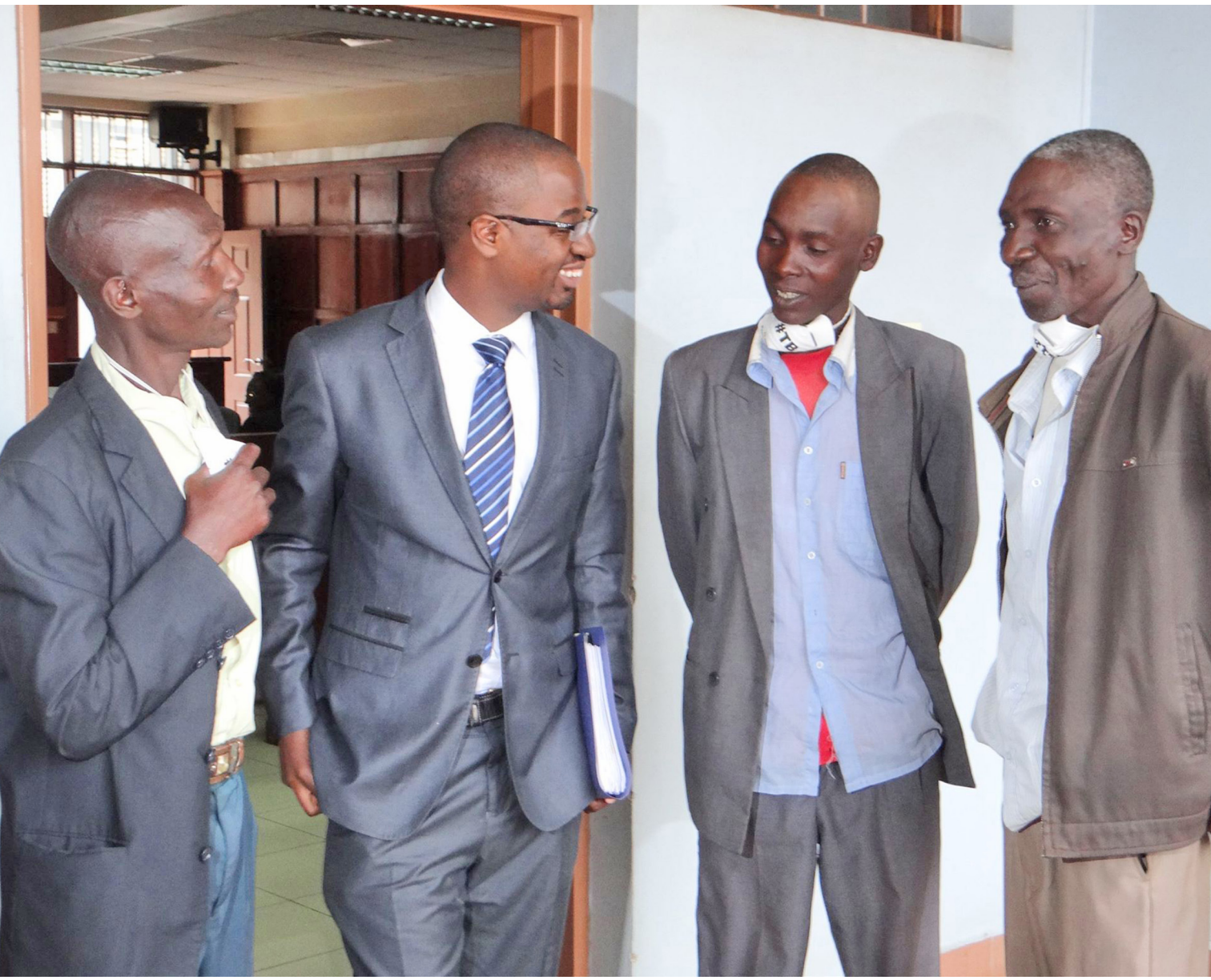
No	Article	Summary	Relevance to TB
6	19 Rights and Fundamental freedoms	This sets outs the basis for the bill of rights noting that they belong to each individual and are not granted by the state	This give a clear legal basis on which one, including person with TB, can demand for his/ her right
7	21 Implementation of rights and fundamental freedoms	An obligation is placed on the state to observe, respect, protect and promote and fulfil the rights and fundamental duties. An obligation is also placed on the state to enact legislation that will ensure the realisation of social economic rights and to also actualise or realise their international obligations. This section also places emphasis on the need to focus on vulnerable groups	This is very useful for TB programming, provision of services, and holding the government accountable on their obligations as relates to human rights. It makes it easier for a persons with TB to hold the government accountable when any of the obligations have not been fulfilled
8	22 Enforcement of Bill of Rights	This provision allows individuals to institute proceedings, prescribes for reduced costs in filing cases relating to human rights and allows individuals and organisations with certain expertise to join onto cases	This is useful for providing an avenue for persons with TB to institute cases when their rights have been violated. It also gives other organisations with expertise in the area to join in the case to make it more stronger
9	23 Authority of Courts to uphold and enforce the Bill of rights	This provision sets out the court which can listen to cases relating to human rights violation and also indicates the possible remedies that can be awarded.	Some of the remedies provided for included compensation, this is useful in cases where persons with TB have suffered rights infringement.
10	24 Limitation of rights and fundamental freedoms	It sets out the legal basis on which rights can be limited. Placing emphasis on the fact that the limitation must be justifiable	This will ensure that the government does not limit ones rights without following the laid down procedure
11	26 Right to life	It guarantees every person the right to life and allows for abortion in cases where a healthcare worker has determined that the mother's life is in danger. It also sets out the basis when life begins.	It ensures that people are not denied the right to live, by either government laws or polices
12	27 Equality and Non-Discrimination	This provision promotes equal treatment of men and women and outlaws discrimination on the basis of health and other status	This is a useful provision for persons with TB as most of their rights have been violated on the basis of discrimination.
13	28 Human Dignity	Places emphasis on the right of each person to be treated with dignity	It ensures all persons including persons with TB are treated in a dignified manner.
14	29 Freedom and Security of the person	This provision ensure the liberty of the persons and protection from cruel, inhuman or degrading treatment	This provision is relevant in cases where TB patients are arrested arbitrarily for failing to adhere to their treatment without giving them a fair trial
15	31 Privacy	This provides for the right to privacy for one's information	This is relevant in ensuring that information about a person's TB status is kept confidential and is not released without his consent.

No	Article	Summary	Relevance to TB
16	35 Access to information	This allows for one to access public information and any information that is relevant to ensuring protection of their rights	This is a useful provision that allows or dissemination of correct information relating to matters of TB.
17	36 Freedom of Association	This right allows for one to participate and join in activities of any kind so long as they are legal	This provisions allows for the formation of associations such support groups that would allow persons with TB to encourage each other and share useful information.
18	41 Labour relations	This provision sets out the general working standards for employees, it also sets out the rights that the employer has and trade unions	This is important and relevant to TB as it will help ensure those who with TB are reasonably accommodated in the place of work and that their working conditions are fair
19	43 Economic and Social Rights	This contains the right to the highest attainable standard of health including reproductive, right to housing and reasonable standards for sanitation, right to adequate food, right to clean and safe water, right to social security and right to education. The right to emergency medical care is also guaranteed	These are key and interdependent to persons with TB as they complement each other, the right to health will ensure that persons with TB get the treatment that is of the highest standards. The right to adequate food will ensure that they don't take medicines on a hungry stomach. The right to clean water and reasonable housing and sanitary conditions will help avert opportunist infections. The right to social security will help ensure basic support t is given to those who cannot afford to support themselves.
20	46 Consumer Rights	This sets out the rights that consumers have in terms of ensuring they have utilise goods of good quality, get accurate information and their health and economic interests are protected	This relevant in relation the nature and quality of goods and services that are provided to persons with TB.
21	53. Children	This provision sets out the rights of children comprehensively, by providing the right to name and nationality, free compulsory basic education and places emphasis on the best interest of the child	This article has important provisions that would be supportive to children who have TB.

CONCLUSION

Ending TB requires sustained and concerted efforts by all stakeholders. The existence of community structures is a key opportunity that needs to be explored and strengthened. The work of community organizations, community health workers, community health volunteers, and networks of TB patients and affected communities needs strengthening through increase in knowledge, technical assistance and financing. Devolution of health services presents an important opportunity for strengthening of these community structures, for example, through remuneration of community health volunteers.

Inadequate resources and misappropriation of funds creates a situation where the TB programme is both underfunded and inadequate in quality, increasing poor health outcomes and mortality, and furthering the spread of TB, including resistant strains.



KELIN Executive director Allan Maleche with the 3 petitioners (Henry, Daniel and Patrick Ng'etich)

ANNEXTURES

Annexure I: How the Constitution of Kenya Protects TB-Related Human Rights

Annexure II: Questionnaires

THE UNIVERSITY OF CHICAGO THE LAW SCHOOL

KELIN Reclaiming Rights, Rebuilding Lives

Stop TB Partnership

LEGAL ENVIRONMENT ASSESSMENT FOR TUBERCULOSIS: KENYA

KEY INFORMANT INTERVIEW GUIDE

INTERVIEWER INSTRUCTIONS

Greet the key informant. Introduce yourself if you have not had previous personal contact with him or her.
Thank the key informant for taking the time to talk with you about the legal environment for TB. Provide a brief overview of the Legal Environment Assessment and why the interview is being conducted.
Observe demographic characteristics of the key informant. Clarify information as necessary with him or her, asking only for information that cannot be determined from observation. Do not use a checklist with the informant.

GENERAL INFORMATION

Interviewers Name: _____ Interviewer's ID: _____

Respondents Name: _____ Designation _____

Organization: _____ County _____

Date of the interview _____ / _____ / _____

Interview site/setting: _____

Start Time: _____ End Time _____

DEMOGRAPHIC INFORMATION

Gender

- ❒ Male
- ❒ Female
- ❒ Transgender: male to female
- ❒ Transgender: female to male

Age

- ❒ 19–24 years
- ❒ 25–34 years
- ❒ 35–44 years
- ❒ 45 years and over
- ❒ Don't know

Cluster

- ❒ Legal Officer
- ❒ TB Survivor
- ❒ Healthcare Provider
- ❒ KP Consortium/NGOs/PBOs/CSO
- ❒ Other (specify:_____)

Page1

INTERVIEWER INSTRUCTIONS:
Read the following statement to the key informant, or provide the information in your own words, before asking interview questions.

Thank you again for taking the time to talk to me today. As indicated when this interview was arranged, this questionnaire seeks to solicit your honest views, knowledge and perceptions on the legal environment for TB management, control and treatment in Kenya. We will specifically seek to know your knowledge, views and perceptions, attitude and experience on the subject. Every subject matter discussed with you will be treated with all the ethical and confidentiality requirements of Good Research Practice.

The information you provide will remain confidential, and will be used for this purpose only. Participation in this discussion is purely voluntary and there is no penalty for refusing to respond to any question. If you have any questions regarding this study, please feel free to contact: Ms. Lucy Ghati and Timothy Wafula of KELIN, Tel: 0722747382, 0726 419173 respectively P.O BOX 112-00202 Nairobi.

Thank you.

Do I have your consent to continue with the discussion? Yes ( ) No ( )

Do you have any questions to ask me before we begin? Yes ( ) No ( )

Consent to record:

As mentioned, your views/opinions are very important we would like to write everything you say. But we cannot write at the same pace as all of us will be talking. For us not to lose any information, we would like to record this Interview to help us later write down views and opinions. This recording will only be used for the purposes of getting your view correctly and will not be aired anywhere or be used to link anyone to their contribution. The Interview will take approximately one hour of your time.

Do I have your consent to record this Discussion? Yes ( ) No ( )

Signature of Interviewer _____

Date_____

Signature of respondent _____

Date_____

[INTERVIEW QUESTIONS START ON NEXT PAGE]

~~~~~ General Situation and Understanding of TB ~~~~~

1.1 What is the overall situation with regard to TB in Kenya?
1.2 Do people with TB have a right to free TB drugs?
1.3 Are the TB drugs quality-assured?

1.4 Do patients have choices about the location of treatment?
1.5Which TB services do people diagnosed with TB receive at a cost/fee
1.6 Is there adequate and good-quality TB diagnosis and treatment capacity? If not, what are the options to address the gap?
1.7 Who are the most at risk populations for TB in Kenya? Who is at risk of getting TB? Describe whether persons are at increased risk because of legal related barriers.
1.8 Are there specific subpopulation groups that may face increased vulnerability to TB due to access barriers?
1.9 Are prevention, testing, treatment and care initiatives effectively reaching these subpopulations and groups?

1.10 What is the available support to help TB patients complete the full course of treatment?

1.11 Do these subpopulations have access to appropriate health education and information in relation to TB? Is such information medically and culturally appropriate?
1.12 What activities are needed to reach out to these subpopulations?

~~~~~ Structured Interviews for Healthcare Providers ~~~~~

3.1 What kind of TB Services does this health facility provide?
3.2 Are TB and HIV services integrated in this health facility? Does this facility have a programme for Community Based TB Care?
3.3 Does this facility initiate DS-TB and DR-TB treatment?
3.4 Does this facility provide services for continuing TB patients?
3.5 Have any of your patients ever had a period of interrupted treatment? Did the patient ever give any reason for their treatment interruption?
3.6 What is the common reason for TB treatment interruption amongst your patients?
3.7 Have you ever experienced any TB or HIV drug shortages in this facility?
3.8 Are TB drugs always readily available at the health care facility? Are the TB drugs provided free of charge?
3.9 Was the treatment of any of your TB patients interrupted because of the drug shortages?

3.10 Is there HIV testing among TB patients? Are testing and counseling services voluntary, confidential, accessible, affordable and respectful? What are the general guidelines on how you should handle a TB patient from diagnosis through treatment?
3.11 Is there informed and written consent of the patient to HIV testing?
3.12 Do you think HCWs have enough time to explain the TB disease to the patients you attended to?
3.13 Do all health services have laws or policies on non-discrimination on the basis of health status? Are these laws or policies enforced?
3.14 Are health providers trained in principles of non-discrimination and informed consent? Are there penalties if the laws or policies are violated?
3.15 What happened to the patients who refuse to consent to TB treatment?

Legal Environment Assessment for Tuberculosis in Kenya

Inter-county dialogue forum on TB and Human Rights

Kisumu, Kenya
18 May 2017

AGENDA

Dialogue Objective:

To identify key human rights issues in TB prevention, treatment, care and support in Kenya for TB high burden counties (Kisumu, Kakamega, Homabay and Busia)

TIME	SESSION	FACILITATOR
8:30 am – 9:00 am	Arrival and Registration	KELIN
9:00 am- 9:30 am	Introductions	Lucy Ghati
9.30 am – 9.40 am	Welcoming remarks	Dr Timothy Malika *Kisumu County TB Coordinator*
9.40 am – 10.00 am	*Setting the scene:* Purpose of the dialogue & why a legal environmental assessment	Lucy Ghati
10.00 am – 11. 00 am	TB Prevention and Management at the county level: Legal and Policy implications on Human Rights: *Panel presentation: perspectives of County TB coordinators* • *Timothy Malika (Kisumu)* • *Carolly Migwambo (Homa Bay)* • *Bernard Bosire (Busia)* • *Emily Vaguza (Kakamega)*	*Moderator:* Timothy Wafula
11.00 am – 11.30 am	**TEA BREAK**	
11.30 am – 12.30 pm	TB prevention and management at the county level: implications of practices on human rights • *Panel Presentation: Perspectives of communities and civil society organizations*	*Moderator:* Lucy Ghati
12.30 pm – 1.00 pm	Plenary discussion on TB policies and practices at the county level	KELIN
1.00 pm – 2.00 pm	**LUNCH**	
2.00 pm – 3.00 pm	Legal, policy and practical issues in the TB response: barriers to realisation of human rights • *Panel presentation: Perspective of prison officers and health care workers*	*Moderator:* Timothy Wafula
3.00 pm – 4.00 pm	Next steps and recommendations to the Legal Environment Analysis	Edgar Makona
4:00 pm – 4:15 pm	Closing Remarks	Onyango Ondeng *KELIN*
	TEA BREAK AND DEPARTURE	


#TB
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Promote adherence
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