Your Ref: TBA **Our Ref: C/KELIN/2010** **Date: 8th September 2010**

1. **Hon. Beth Wambui Mugo E.G.H., M.P**
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2. **Hon. Peter Anyang' Nyongó E.G.H., M.P**
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5. **Hon. S. Amos Wako EGH, EBS, FCI Arb, SC,**
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   NAIROBI.

Dear Sirs,

RE: ARREST AND IMPRISONMENT OF DANIEL NGETICH AND PATRICK KIPGETICH KIRUI IN KAPSABET FOR DEFAULTING IN TAKING OF THEIR TUBERCULOSIS (TB) TREATEMENT – MISC. CRIMINAL CASE NUMBER 46 of 2010

A condemnation of the Act of arrest of imprisonment by members of Civil Society Organisations (CSOs), TB Patients and Communities working on health and human rights issues.

Following local and international media reports on the above case, various members of Civil Society Organisations working on health, HIV and human rights have individually and severally travelled and investigated the case and would like to issue the following advisory note with respect to this case.

Facts of the Case

As found, Mr. Daniel Negtich, Mr. Henry Ngetich and Mr.Patrick Kipngetich Kirui were arrested on the 12th day of August 2010 on the basis of the fact that they had severally defaulted on their periodical prescribed medical treatment for TB. On their arrest they were remanded in the Police cells with other accused person's in remand. Daniel and Patrick were arraigned before the Principal Magistrate at Kapsabet court. Due to his seriously poor health condition, Henry was taken to the Kapsabet District Hospital and has since been admitted there where he is receiving medical care. Mr. Zachariah Maina Bett, a Public Health Officer in Nandi Central District, swore the affidavit that formed the basis for the magistrate's order of confinement in prison of Daniel and Patrick.

The key arguments in the affidavit were:

I. That the Nandi Central District Tuberculosis and Leprosy Coordinator, who swore the affidavit, had information that the two respondents are tuberculosis patients under medication.

II. That the respondents have severally defaulted periodical prescribed medical treatment

III. That they had exposed the general Public of Kiropket area and their immediate families to the risk of contracting Tuberculosis.

The officer did not provide any supportive evidence to prove his allegation particularly the fact that the respondents were infectious and the particulars of the danger that they had paused to the public Kiropket Location.

He applied for orders that the two be confined in isolation at Kapsabet GK prison for treatment under supervision for a period of eight (8) months.

On the basis of this affidavit the Magistrate issued an order on the 13th of August 2010, confining the two at the Kapsabet GK Prison in Isolation for 8 months for purposes of Tuberculosis treatment.

Though the court record reflects that the accused had no objection, we are informed by the accused persons that they were advised not to reject any court decision in the negative as doing so would see them being keep in remand for longer in bad conditions; consequently we are of the view that the respondents had no information as to what they were getting themselves into and cannot be said to have made an informed choice in their response to the magistrate.

WHY WE OBJECT

We would like to clearly state that we encourage and would support the Ministry of Public Health and its officers in efforts to ensure adherence to treatment by those on such treatment. We would like, however, to caution against arbitrary misuse of the law enforcement facilities for the following reasons:

In our view, the provisions of *Section 27* the Public Health Act, were not applied and interpreted correctly and were in no way utilised to protect the interests of the members of the Public as envisioned by the Act. We raise this concern for the following reasons:

I. The correct procedure was not utilised to enforce the provisions of *Section 27*, whereas the section provides for a certificate signed by the medical officer for health none was presented to the court, and in any event the affidavit produced in court had no supporting documents to verify the allegations made by the officer.

II. The manner in which the accused were treated actually indicates that the whole process was an abuse of the court system and the action taken was not in the public interest as they were held in remand with other members of the public at the police cell and were taken and are still being held together with other prisoners at the Kapsabet G.K Prison, contrary to the purpose of sections 27 and in disregard of the officers fears that they are infectious and a danger to other members of the public and other prisoners.

III. Whereas we are not challenging the validity of *section 27*of the Public Health Act, we advise that even where it is invoked, the place of detention for purposes of protecting members of the public from infection, should be health settings rather than prisons; we have analysed the Prisons Act, Chapter 90 of the Laws of Kenya and our discussions with the prisons wardens at the Kapsabet GK Prison, reveals that there are no requirements and facilities for isolation of prisoners.

IV. The measures employed go contrary to the internationally recommended TB Patients charter which spells out the right and responsibilities of TB patients and they send the message that we are a society that is intent on criminalising TB patients with defaulter records; it is likely to send a fear in the general population, increase stigma and also undermine the public health interests as many people will fear coming forward for TB testing and treatment which poses greater danger to the public. Indeed some of the members of NEPHAK member organisations are already calling to inquire whether they will be arrested for defaulting from taking Antiretroviral Drugs (ARVS). A total misinterpretation of the situation but one that has created negative social fear that will require more investment in education and information in order to be reversed.

These reasons point to perpetuation of the historically coercive model of tuberculosis control, a model that disempowers patients and communities and indicate clear violation of rights, alienation of TB patients, and reinforcement of stigma, thereby undermining the very outcomes that the Public health officer hopes to achieve in their treatment programmes.

Despite registering some progress, the National TB Programme faces some glaring challenges. The current example of Daniel and Patrick best illustrate this. The case confirms that community and patient participation in National TB programmes remains a dream. Indeed, patient-centred approach although articulated in National and International strategies has been neglected in practice. We regret that 2 years after the Minister of Public Health and Sanitation Hon. Beth Mugo launched the International standards of TB care, together with the Patients Charter; no resources have been allocated to enable the implementation of these strategies.

We must also point out the missed and messed opportunities, which if were prudently utilized, then our National TB Programme would register milestones. We particularly single out the Global Fund to fight AIDS TB and Malaria (GFATM) Round 5 (TB) grant which uniquely had a provision for civil society organizations (CSOs) and community groups to scale up advocacy, communication and social mobilization (ACSM) as part of the national response to TB. As we write this advisory note, phase 1 of this grant was completed in 2008 and 2 years down the line, phase 2 is yet to start. The grant is in the country and not being utilized. We cannot forget to mention that the same GFATM had a grant for the construction and equipping of isolation facilities for MDRTB patients. Since 2005, the isolation wards have not been completed. These are missed if not messed opportunities.

As we finalise, we wish to recommend that:

I. The Public health policy makers and officers should combine medical and socio-cultural aspects, TB patient empowerment and community mobilisation to ensure effective mobilization for better behaviours in the management of infectious and other diseases.

II. The use of the patient and community centred approach, as clearly spelt out in component No 5 of the Stop TB Strategy, on empowering TB patients and communities, already incorporated the blue print that countries use in TB control , is paramount to avert future cases of this nature.

III. We urge the government ministries to ensure the prudent utilisation of resources that have been availed to the Country, to help improve the standard of care of persons who have infectious diseases.

IV. There is evidence that community based programmes for TB care work and we ask the government to adopt programming that upholds both public health and human rights since they are not mutually exclusive.

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SIGNED BY Kenya Legal & Ethical Issues Network on HIV & AIDS KELIN (KELIN) on behalf **THE FOLLOWING ORGANISATIONS**

National Empowerment Network of People Living With HIV and AIDS Kenya (NEPHAK)

Advocacy To Control Tb Internationally – Action Kenya

Action Aid International Kenya (AAIK)

Aids Law Project Kenya (ALP-K)

Kenya Aids NGOs Consortium (KANCO)

Health Rights Advocacy Forum (HERAF)

Network of Men Living With HIV & AIDS in Kenya (NETMA)

Positive Families Network (+fn)

Alliance for Care and Prevention of Tuberculosis in Kenya (ACT KENYA)

TB Patients Support Self Help Group

Maximizing facts on AIDS (MAXFACTA)

Lean On Me Young PLHIV Group

Kenya Network of HIV Positive Teachers (KENEPOTE).

Nandi County Networks of PLHAs

CC;

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