SECOND REGIONAL CAPACITY BUILDING FORUM ON HIV AND T.B, HUMAN RIGHTS AND THE LAW FOR LAW ENFORCEMENT OFFICERS AND HEALTH CARE WORKERS

VENUE: SAROVA WHITE SANDS, BEACH RESORT AND SPA, MOMBASA, KENYA.

Report

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Design and Layout by Impact Africa Ltd.
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Nairobi, Kenya
# TABLE OF CONTENTS

ABBREVIATIONS.................................................................................................................................................. II
EXECUTIVE SUMMARY.................................................................................................................................... 1
CONFERENCE OBJECTIVES................................................................................................................................. 2
INTRODUCTION AND BACKGROUND.................................................................................................................. 3
DAY 1, WEDNESDAY, 7 JUNE 2017..................................................................................................................... 4
WORKSHOP INTRODUCTIONS............................................................................................................................ 4
WELCOMING REMARKS.................................................................................................................................... 5
SESSION 1: COMMUNITY EXPERIENCES ON ACCESS TO TB SERVICES...................................................... 8
DISCUSSANTS PERSPECTIVES............................................................................................................................ 10
SESSION 2: THE SCIENCE OF TB: KEY POPULATIONS AT CORE OF TB INTERVENTIONS................................. 11
DISCUSSANTS PERSPECTIVES............................................................................................................................ 12
SESSION 3: HIV, TB AND KEY POPULATIONS: THE ROLE OF THE LAW..................................................... 13
DISCUSSANTS PERSPECTIVES............................................................................................................................ 17
DAY 2, THURSDAY, 8 JUNE 2017....................................................................................................................... 17
KEY NOTE ADDRESS........................................................................................................................................ 17
DISCUSSANTS PERSPECTIVES ON FIELD VISITS............................................................................................ 18
SESSION 4: THE ROLE AND EXPERIENCE OF JUDICIAL AND OTHER CRIMINAL JUSTICE ACTORS IN ADVANCEING ACCESS TO HIV AND TB SERVICES FOR KEY POPULATIONS................................................................. 20
DISCUSSANTS PERSPECTIVES............................................................................................................................ 23
SESSION 5: REGIONAL LAWS AND POLICIES AND THEIR PLACE IN GUARANTEEING ACCESS TO HIV & TB SERVICES FOR KEY POPULATIONS......................................................................................................................... 24
DISCUSSANTS PERSPECTIVES............................................................................................................................ 27
SESSION 6: GOOD PRACTICE MODELS FROM LAW ENFORCEMENT OFFICERS AND HEALTH CARE WORKERS.............................................................................................................................................. 28
DISCUSSANTS PERSPECTIVES............................................................................................................................ 31
SESSION 7: HOW DO WE FIND THESE MISSING POPULATIONS IN THE FIGHT AGAINST TB?................. 32
DISCUSSANTS PERSPECTIVE............................................................................................................................... 34
SESSION 8: ACTION PLANNING........................................................................................................................ 35
CLOSING REMARKS BY HON. EMMANUEL DAVID OMBUGADO, MEMBER OF PARLIAMENT – NATIONAL ASSEMBLY, NIGERIA............................................................................................................................................. 47
APPENDICES...................................................................................................................................................... 48
**Abbreviations**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ARASA</td>
<td>AIDS and Rights Alliance for Southern Africa</td>
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<tr>
<td>CSO</td>
<td>Civil Society Organisation</td>
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<tr>
<td>EAC</td>
<td>East African Community</td>
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<td>EANNASO</td>
<td>The Eastern Africa National Networks of AIDS Service Organisations</td>
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<td>FSW</td>
<td>Female Sex Workers</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>IDU</td>
<td>Injecting Drug User</td>
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<tr>
<td>KELIN</td>
<td>Kenya Legal and Ethical Issues Network on HIV/AIDS</td>
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<tr>
<td>KP</td>
<td>Key Populations</td>
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<tr>
<td>LGBTI</td>
<td>Lesbian, Gay, Bisexual, Transsexual and Inter-sex</td>
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<td>MDR TB</td>
<td>Multi-Drug Resistant Tuberculosis</td>
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<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
</tr>
<tr>
<td>PLHIV</td>
<td>People living with HIV</td>
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<tr>
<td>PWUD</td>
<td>People/person Who Use Drugs</td>
</tr>
<tr>
<td>RMNCAH</td>
<td>Reproductive, Maternal, Newborn, Child and Adolescent Health</td>
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<tr>
<td>SADC</td>
<td>Southern African Development Community</td>
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<td>SALC</td>
<td>Southern Africa Litigation Centre</td>
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<tr>
<td>SRHR</td>
<td>Sexual Reproductive Health Rights</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TWG</td>
<td>Technical Working Group</td>
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<tr>
<td>W.H.O</td>
<td>World Health Organization</td>
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<tr>
<td>XDR TB</td>
<td>Extensively Drug Resistant Tuberculosis</td>
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**EXECUTIVE SUMMARY**

Tuberculosis (TB) remains an important public health problem in Sub-Saharan Africa and its vulnerability within the continent has resulted in it being one of the major beneficiaries of The Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund). The Global Plan to End TB outlines the following targets to be achieved by 2020, or 2025 at the latest.

The Plan refers to people who are vulnerable, underserved or at risk of contracting TB and provides models for investment packages that will allow different countries to achieve the 90-(90)-90 targets. To achieve these targets the Stop TB Partnership, KELIN and the International Human Rights Clinic, University of Chicago Law School formed the TB and Human Rights Consortium and drafted the Nairobi Strategy to develop and implement a human rights-based approach to TB.

Deprived isolated communities within environments constitute a challenge for TB control. The association between TB and key populations is mediated by overcrowding, poorly ventilated housing, malnutrition, smoking, stress, social deprivation and poor social capital. The perceptions of health and illness in key populations are altered resulting in a negative impact on health-seeking behaviors and access to services.

Important factors include disrupted social networks, social exclusion, reduced accessibility to health care, lack of egalitarian participation in society and lack of trust, understanding or respect for the system. Women, unemployed and homeless people experience longer delays in seeking care resulting in increased suffering and expenses and higher risk of community transmission.

The Second Regional Forum for law enforcement and healthcare workers was convened with the support of the Global Fund through a regional grant administered by the United Nations Development Programme (African Regional Office) and implemented by KELIN in partnership with ARASA.

Enda Santé and SALC and it is aimed at addressing 10 sub-Saharan countries namely: Nigeria, Cote D’Ivoire, Senegal, Malawi, Seychelles, Kenya, Tanzania, Uganda, Zambia and South Africa.

The conference was an occasion for knowledge sharing between law enforcement, healthcare workers, civil society and members of key populations (KPs). The forum uniquely benefited from the perspectives of law enforcement officers, health care workers, civil society, persons living with HIV and key populations, who included representatives of sex workers, men who have sex with men, the transgender community and injecting drug users.
CONFERENCE OBJECTIVES

The overall objective of the Conference was to:

- To enhance the understanding of the linkages between HIV, TB, human rights and the law as they affect key populations.
- To sensitise stakeholders on the rights based approach to providing health care services to key populations.
- To foster regional and in-country partnerships for increased advocacy and lobbying for removal of legal barriers which impede access to health care by key populations.
INTRODUCTION AND BACKGROUND

Key populations experience high TB prevalence due to social and demographic risk factors such as poverty, unemployment, homelessness, imprisonment, HIV infection, malnutrition and lack of access to health care. The law is a mechanism through which social determinants are transformed into health and development outcomes. However, laws that are not grounded on human rights principles create social inequalities and exacerbate human rights violations against vulnerable groups.

For example, laws that criminalise the actions and behaviours’ of key populations have necessitated stigma, discrimination and violations against men who have sex with men (MSMs), sex workers, transgender persons and people who use drugs (PWUDs). Integrated services for HIV/AIDS and TB facilitate treatment monitoring, early identification of side-effects and development of joint strategies to maximise adherence to both treatments. IDUs require comprehensive care services (e.g. HIV/AIDS, chemical dependency treatment, DOTS, hepatotoxicity monitoring particularly in patients with hepatitis B or C infection or alcoholism) and should be managed by experienced health teams.

If comprehensive care is not possible, cooperation, constant communication and adequate referral systems between TB and HIV/AIDS programmes are pivotal. Strategies to stimulate treatment adherence should be available (adherence groups, psychological support, day and night hospitals). Methadone programmes improve adherence to INH prophylaxis, thereby decreasing TB incidence. Psychosocial support should be offered to individuals with treatment adherence difficulties.
DAY 1, Wednesday, 7 June 2017

WORKSHOP INTRODUCTIONS

Retired Justice Violet Mavisi and Mr Ted Wandera instigated the conference by requesting the participants to introduce themselves. Significantly, the participants were asked to mention one myth or fact about TB that they are conversant with. The ripostes given revealed the various perceptions of the healthcare workers and law enforcement officers, and some key highlights are outlined below:

✓ Social conditions that continue to drive the TB epidemic.
✓ Need for targeted multi-sectoral interventions to improve access and ensure adequate diagnosis, treatment and follow-up of TB cases.
✓ Raising TB awareness within the general public is important.
✓ Community participation increases TB awareness and sensitises the community to TB interventions.
✓ Economically poor and vulnerable populations are all at greater risk of TB infection and disease and are likely to have worse treatment outcomes than the general population.
✓ Psychosocial support should be offered to individuals with treatment adherence difficulties.
✓ A competent referral system is critical to coordinate efforts and ensure treatment success.
WELCOMING REMARKS:

Allan Maleche,
Executive Director, KELIN

Mr Maleche gave the welcoming remarks beginning with a brief background to the Second regional Forum. He explained that the Stop TB Partnership’s Global Plan to End TB 2016–2020 calls for a human rights- and gender-based approach to TB grounded in international, regional, and domestic law. The Global Plan acknowledges that TB programming will not be successful unless global and national programs ground their work in human rights and gender equity.

He stressed that as part of the Global Plan’s implementation, the TB and Human Rights Consortium, whose members include the Stop TB Partnership, University of Chicago Law School International Human Rights Clinic, and KELIN (Kenya) has launched an inclusive, consultative process to promote adoption of the Nairobi Strategy on TB and Human Rights. Led by people with TB, TB survivors, and other allies, the strategy aims to implement several streams of work to foster diverse, focused, and sustained advocacy efforts.

Mr Maleche highlighted that The AIDS and Rights Alliance for Southern Africa (ARASA) and UNDP Regional Service Centre for Africa, under the Africa Regional Grant on HIV: Removing Legal Barriers will host the second Africa Regional Dialogue on HIV, TB and the Law on 3-4 August 2017 in Johannesburg, South Africa.

He requested participants to make submissions based on their thematic areas, that is, stigma and discrimination, legal aid responses, legal frameworks and access to justice, laws and practices that mitigate or sustain violence and discrimination lived by women, laws and practices that facilitate or impede treatment access, law and HIV pertaining to children and young people and laws and practices that effectively criminalise people living with HIV and key populations at higher risk of HIV and those at risk of TB.
Speaker: John Njenga, Key Population, TB Survivor

He shared his story on how he developed a cough that lasted over six weeks. At first he tried various over-the-counter medicines, but nothing cured the cough. At the time, he was an active drug user and smoker and believed that smoking had caused his cough. When he began coughing up blood, he became frightened and sought treatment from a local physician, who advised him to stop taking drugs and smoking and prescribed a syrup medication. But, he did not take heed to the professional help.

Eventually, his health deteriorated and he went to a nearby City Council hospital and took an x-ray of his chest. He was later referred to the Kenyatta National Hospital, where his TB was diagnosed. He explained that the news was hard to take.

At first, he went into denial and refused to begin treatment and used more drugs because he felt empty and even became depressed. He knew the illness was severe and people in his community would shun him if they knew he had TB on top of being a drug user.

Noticing his distress, family began to counsel and reassure him and encouraged him to begin the TB treatment. He admitted to have defaulted the treatment a couple of times due to terrible side effects such as nausea, vomiting, loss of appetite, and excruciating joint pain. Stigma and discrimination from friends on seeing how emaciated he had become, they believed he had HIV and were scared to interact with him. He said most people also looked at him suspiciously and avoided him.

He concluded by saying that Methadone helped him to adhere to his treatment, which eventually cured him completely.
Speaker: Rd. Lucica Ditiu – Executive Director Stop TB Partnership (Switzerland) – Via Video.

She explained that the institutional and community norms that lead to the stigmatisation of tuberculosis (TB) are a hindrance to TB control. Stigma, which is shaped and promulgated by institutional and community norms and interpersonal attitudes, is a social determinant of health.

She stressed the need to collect proper data using validated survey instruments to quantify the impact of TB stigma on TB diagnostic delay, treatment compliance, and morbidity and mortality and develop additional TB stigma-reduction strategies.

Video Session: TB is not a Crime

The video highlighted the journey of two brothers who were arrested, charged and sentenced to 8 months in prison for defaulting on their TB medication.
SESSION 1: COMMUNITY EXPERIENCES ON ACCESS TO TB SERVICES.

MODERATOR: DR MABUMBA, PRINCIPAL MEDICAL OFFICER, NATIONAL TB PROGRAMME UGANDA

The aim of the session was to highlight the challenges community members face in accessing TB services both in prison and when in the general populations.

The aim of the session was also to allow participants to get a grasp and internalise challenges faced in accessing TB services.

Speaker: Apollo Ndirangu

He talked about his inexplicable and rapid weight loss and vomiting. He thought he had cancer. He sought medical attention and was diagnosed with TB. He started taking medication but after a while, he had to go back to work and sought to speak to his doctor about his hours of medication. However, his doctor did not make any changes to fit in Ndirangu’s schedule and he ended up defaulting on his TB treatment.

The doctor went ahead and reported him to the police authorities who arrested him and was arraigned in court for refusing to comply with a tuberculosis order to be at the clinic at certain times and make appointments to take his medication. He was jailed for 6 months and had to re-start the TB medication. He said that the TB treatments and the jail term were both a financial and an emotional burden and not receiving medication and on time because of the doctor’s laxity caused a tremendous amount of suffering, not only to him but also to his family.

He emphasised that the support of his family and community played a significant role in easing the pain caused by the disease and helped him to recover fully.
Mr Rafube explained that many prisons are overcrowded well beyond their official capacities. Overcrowded prisons facilitate the spread of TB because prisoners are in close contact with one another, often for 12 hours or more a day without access to the outside. Overcrowding, poor ventilation due to inadequate infrastructure (lack of windows) or windows covered by prisoners (to block cold air from entering the room in cold climates or by hanging of clothes on bars), and prolonged confinement inside cells are all factors conducive of transmission of airborne diseases.

Furthermore, many prisoners are heavy smokers, injecting drug users, homosexuals, adding to the unhealthy atmosphere in overcrowded cells, and standards of hygiene are often poor. Living together in cramped quarters, with little or no ventilation, is another major factor for contracting TB.

Moreover, new prisoners are often put into cells without an accurate health check and, in many settings, without routine screening for TB. A prisoner with undetected TB may thus be pooled with other prisoners in an unhealthy cell setting, putting all its occupants at risk of contagion. These daily conditions of prison life promote TB transmission.

He said that laboratories inside prison facilities are often inadequate or nonexistent, delaying referral of prisoners to outside health services. These limitations also lead to high TB rates in prison facilities, likely contributing to transmission to wider communities.
He highlighted that in some instances, bribery and commercialisation of anti-TB medicines have been identified. Prisoners may try to hoard anti-TB medicines for their own use, and a black market can develop.

Prisoners may use anti-TB medicines as an alternative prison currency. They may sell the medicines to the guards, give them to their relatives during family visits, or use them in gambling or paying debts.

**DISCUSSANTS PERSPECTIVES**

- The social stigma associated with incarceration, combined with the depersonalising effects of imprisonment, may result in a sense of hopelessness and powerlessness, as well as deeply internalised shame and guilt. It is crucial to integrate psychosocial support at all programmatic levels, to address the trauma of the incarceration itself as well as a prison culture that conflicts with treatment goals.

- It is vital to assimilate continuous individualised treatment planning and focused treatment modules as well as group counseling with recovering role models provide support and guidance.

  This is imperative after individuals leave prison, to address issues of anger management, moral problem solving, addiction awareness, relapse prevention, early memories, trauma recovery, social skills, and empowerment.

- There is need for policy and legislation to address on aftercare and continuity of care especially relevant to IDUs with TB, HIV and Hepatitis C, as they are particularly in need of continuing treatment to stabilise their positive gains and to promote integration with the mainstream community.

- Moreover, there is need for policy and legislation to tackle overcrowding in prisons, late detection and treatment of TB cases among prisoners, and poor airborne infection control measures which all factors are contributing to transmission of TB.

- Preventive measure for TB control in prisons is crucial, chiefly, prompt detection of TB among prisoners should be ensured through a combination of screening methods (screening on entry, mass screening at regular intervals, passive screening, contact screening) based on clinical questionnaires, chest X-rays and smear microscopy.

- Capacity-building for public health and prison personnel is crucial for delivering good quality and effective TB/HIV interventions in prisons.
SESSION 2: THE SCIENCE OF TB: KEY POPULATIONS AT CORE OF TB INTERVENTIONS

MODERATOR: DEENA PATEL – UNDP

The session aimed to equip participants with information on the science of TB and how it is transmitted.

It also gave participants a guide to TB and key populations, the work that Stop TB is doing with key populations and TB and developments in the Global arena with regard to TB and key populations.

Speaker: Colleen Daniels, Human Rights, Gender & TB/HIV Advisor – Stop TB Partnership (Switzerland)

She explained that the target is to reach and place 90% of all people on treatment for TB, DR-TB and preventive therapy.

She stressed that challenges including old diagnostics, long, toxic treatment regimens, vaccines that do not work for all, for instance BCG given to children, medicalised and conservative approaches as well as lack of community engagement continue to inhibit the fight against TB.

In addition, slow roll out of new tools such as GeneXpert, Bedaquiline, and Delamanid, delayed and limited funding plus a lack of understanding of the disease and more so human rights abuses, continue to obstruct the Stop TB programme. She highlighted the opportunities that could positively evolve the fight against TB such as; scaling up planning and implementing effective programmes and activities towards TB control to especially eliminate TB deaths in people living with HIV and in prisons.
Also, programme managers should know their epidemic for targeted programmatic interventions and develop a focused approach to finding, preventing, and treating tuberculosis as well as diagnosis and treatment of “latent” tuberculosis infection.

**DISCUSSANTS PERSPECTIVES**

- It was highlighted that in Uganda, while there are 140 GeneXpert machines available for TB screening, there is still a lack of follow-up using sputum smear investigation by microscopy for patients whom pulmonary TB has been diagnosed, and are considered to be at risk of harbouring MDR-TB bacilli. Granted, it has some technical shortcomings, but its operational advantage is obvious since a diagnosis may be established with certainty and treatment started on the same day.

- Colleen Daniels emphasised that every piece of artillery in prevention and cure of TB should be considered including active case-finding that involves the screening of key populations at different points during their clinic visits and the use of various methods, including questionnaires, chest radiography, tuberculin skin testing and immunoglobulin gamma interferon assay (IGRA), or a combination of these methods.

- The participants explained that there is general deficit of funding for TB programmes at country level and underscored that International donor funding is critical to sustain gains and accelerate impact. It was underlined that countries need to raise awareness about the shortfall in funding as well as pressure governments to change funding policies and commit to support, so as to fill this deficit so that TB research, development and programmes can grow apace with community demands.

- It was emphasised that the TB epidemic in Sub-Saharan countries with a high rate of HIV has also accelerated and people who were co-infected with TB and HIV continue to die.
It was agreed that current approaches to preventing, diagnosing, and treating TB are inadequate without community participation, which is a principal aspect to improving understanding of tuberculosis transmission dynamics, in order to plan more targeted, effective prevention interventions. It was stressed that it is important to critically consider funding and programme priorities that are being set and who is setting them, since policymakers and funders often prefer a biomedical approach to disease control and pay less attention to addressing more complex socio-political realities and their impact on the causal pathways of TB.

✓ The participants explained that the management of TB in children is challenging, first because of the limited and delayed suspicion of TB, due to the lack of specificity of signs and symptoms, and the torpid clinical evolution in this population.

✓ It was agreed that it is crucial to identify a focal person at the community level during field interventions, one with useful information to support the diagnosis, and well-characterised symptoms, which may help the diagnostic accuracy in older children and in very young children.

SESSION 3: HIV, TB AND KEY POPULATIONS: THE ROLE OF THE LAW
MODERATOR: MR MIRAJI MAMBO – LEGAL OFFICER – TACAIDS

The aim of the session is to highlight the importance of the ‘Nairobi TB Strategy’ and key things for law enforcement officers and health care workers to take into account.

Speaker: Allan Maleche, Executive Director - KELIN

He outlined the key components of the Nairobi Strategy as follows:

✓ Support networks of affected communities of people with TB, TB survivors and civil society at global, regional and national levels.
Enhance judiciary and legal communities’ awareness on implementation of a human rights-based approach to TB.

Expand legislators’ and policymakers’ capacity to incorporate human rights based approaches to TB into laws and policies.

Engage and advise international organisations and experts on the implementation of human rights based approach to TB into global policies and programs.

Sensitise health care workers in public and private sectors on the need to incorporate a human rights-based approach to TB in their work.

Formulate and clarify the conceptual, legal and normative content of a human rights-based approach to TB.

Conduct qualitative and quantitative research to generate evidence based for the effectiveness of a human rights-based approach to TB.

The second Africa Regional Dialogue will continue to identify key HIV, as well as TB, issues of critical concern. It will include a strong focus on understanding what has been done to follow up on the recommendations from the first Africa Regional Dialogue, and what has worked to bring about change. Mr Malache stated that the Dialogue was interested to hear how laws and policies have changed, if at all, and whether this has impacted upon lives; how education and training have helped to empower populations and to change attitudes, if at all, and whether populations are better able to access support and mechanisms to enforce their rights.

He explained that the second Africa Regional Dialogue, which will bring together 140 government and civil society participants from across Africa, would also discuss progress on the implementation of the findings and recommendations of the Commission on HIV and the Law in the region, highlight issues and concerns that continue to face challenges and make strategic suggestions and recommendations on the way forward.

The key objectives of the forum were:

To provide a platform for a range of stakeholders from different sectors, including people living with HIV/TB, key populations, civil society and government, to engage in evidence informed discussions on priority HIV, law and human rights issues of regional and national concern.
To reflect on the extent to which the findings and recommendations of the Global Commission on HIV and the Law have been implemented and to evaluate the impact of these initiatives on HIV, law and human rights issues.

To identify current challenges and obstacles that continue to impede access to justice and to HIV/TB treatment, care and support services.

To share Model Laws, good practices and lessons learned from work undertaken in the region to date on implementing the findings and recommendations of the Global Commission on HIV and the Law and strengthening the legal and policy environments regarding access to HIV/TB, health and social services.

Speaker: Annabel Raw – Health Rights Lawyer, SALC

She explained that the barriers to TB prevention, treatment, care and support for key populations include criminalisation, lack of evidence for programming, stigma and discrimination, limited or no access to TB information, limited capacity of health workers to deal with key populations, and human rights violations against key populations.
She stated that the rule of law can at times be a buffer, as it tends to criminalise, and legal and policy barriers play a key role in vulnerability to TB/HIV. Moreover, fear of arrest and harassment drives key populations underground. Many public health interventions targeting key populations are not supported or prioritised and health personnel are ill equipped to address the specific needs of key populations.

She stressed that key populations experience further barriers to quality health care due to widespread stigma within health systems and the community. Stigma and discrimination are major barriers to public services and undermine public health and human rights and ultimately the response to HIV.

**Speaker: Timothy Wafula, KELIN**

He elucidated that a National Action Plan meeting was held in March, 2017 where stakeholders had an opportunity to critique recommendations made in two legal environment assessment reports on laws and policies affecting access to HIV and TB services for key populations.

He explained that moving forward, human rights activities would have to be included in National Strategic Plans and implementing partners’ work plans. Through dialogues with key populations and domestic and or regional human rights experts.
DISCUSSANTS PERSPECTIVES

✓ It was highlighted that there are gender dynamics in TB enrolment, treatment and cure rates, thus a systematic assessment from a gender perspective on health seeking and treatment behaviour of men and women living with HIV, HIV/TB co-infection or suffering from TB, will ameliorate to inform national planning and budgeting for gender-responsive and gender-transformative TB and HIV responses.

✓ It was proposed that Community Health Volunteers should be absorbed at the county level in Kenya, since health is a devolved function. The CHVs can be further trained to aid in community research on the TB knowledge, attitudes and practices of men and women in order to inform policy and programmes Development. This will facilitate collaboration between national and county line ministries of education, health, gender and as well as research institutions on communicable diseases, in order to conduct pertinent, more so gender-focused research and generate findings that can inform the development of strategic TB prevention and control intervention.

DAY 2, THURSDAY, 8 JUNE 2017

KEY NOTE ADDRESS

Speaker: Justice Mumbi Ngugi – Presiding Judge High Court of Kenya in Kericho County
She commended KELIN for organizing the workshop that increased her awareness on the felt needs of key populations and assist her to make informed decisions as a judge. She stressed that even if people know their rights, they may not be able to assert their rights without assistance from legal or paralegal professionals. She said that in key populations’ circumstances, access to legal assistance may be the most direct and effective way for them to get access to TB services or to be protected from and to address stigma and discrimination.

She stated that jail-term for non-compliance with TB treatment may not be the best option, since in prison, patients endure conditions that could only exacerbate their illness, including overcrowding and poor diet. She said that training of police, judges, and other law enforcement and judicial personnel is an essential activity to ensure the effectiveness and uptake of TB services.

Also, training of prison medical personnel, as well as guards and other prison staff, on the basics of TB prevention and care can be effective as people in prison and pretrial detention have the right to the same quality health services as those provided in the community.

She explained that rights literacy is crucial, especially for key populations already prone to discrimination and exclusion and without good access to mainstream information sources. Hence, it is best to combine rights literacy with measures that improve access to legal services.

She concluded by saying that since health is a devolved function in Kenya, counties should develop measures to combat problematic policies and laws that do more harm than good, where TB and HIV is concerned.

**DISCUSSANTS PERSPECTIVES ON FIELD VISITS**

Participants made field visits to Shimo La Tewa Main Prison, Kisauni Clinic providing Harm Reduction and TB services to key populations and Magodoroni site where outreach workers provide harm reduction other health interventions to drug users.

The participants noted the following:

- Seemingly, there is inadequate provision medical provision and of food and nutritional supplements at the harm reduction site and prisons, since they are in food-insecure environments’, which contributes to treatment non-adherence in TB programmes. Moreover, the participants detected a sense of hopelessness among the key population, regarding safe and supported transition into the community.
The clinic lacked a trained psychosocial officer to offer psychosocial support as well as an infection control officer who should be responsible for overseeing the implementation of infection control measures and providing infection control training for health care and other staff members who may be exposed to TB infection.

Notably, the workers in the clinic lacked respirators which should provide reasonably good protection against TB to health-care workers in close contact with TB patients.

This protection is particularly important when health staff are supervising a cough-inducing procedure (such as bronchoscopy) or sputum collection.

The participants’ applauded the KELIN and Reach Out teams for organizing such eye opening field visits to three sites.

They highlighted the need for M&E in all programme interventions, as it is useful for strengthening the collection of sex and age disaggregated data, identifying and tracking of gender disparities in relation to HIV and AIDS, TB and informing strategies for enhancing prevention and treatment of HIV based on biological and social cultural factors, and the ways in which this affects health behaviours, outcomes and services for women and men in key populations.

They emphasised on improvement in infection-control by carrying out organisational, administrative and environmental interventions, at all levels.

The participants stressed the need for educational campaigns for the general public, especially directed against stigmatisation and discrimination, which are the greatest threats to TB programmes.

They emphasised that the greatest barriers to continuity of care for TB are adherence to medication, housing, social relationships and unemployment.

They proposed that the county government, non-governmental organisations and faith-based organisations play crucial roles in developing explicit solutions for individuals, over and above helping to follow up key populations, undergoing TB treatment.

Unplanned releases (amnesty, etc.) often create problems with the continuity of TB treatment. The prison administration should inform the health staff about all scheduled and unscheduled releases as soon as information becomes available.
The aim of the session was to equip the participants with knowledge on use of the courts and other judicial processes to advance health rights for key populations. Ms Kamede explained that there has been growing recognition of the importance of social protection to respond to a range of challenges faced by sub-Saharan countries, including food insecurity, chronic poverty and the HIV pandemic. She stressed that social protection can reduce vulnerability to HIV and TB infection, improve and extend the lives of people living with HIV, and support individuals and households.

Achieving legal and social protection for people and households affected by HIV and TB is a critical step towards the realisation of universal access to prevention, treatment, care and support.
He stated that prisons throughout sub-Saharan Africa are often filled far beyond their capacity. More often than not, overcrowding can be so severe that inmates may be forced to sleep seated, standing, or in shifts, in cells with little ventilation. These conditions violate human rights and may rise to the level of cruel, inhuman, or degrading treatment.

He emphasised that interventions such as reforming bail guidelines, restricting overly broad police authority to detain “co-conspirators,” expanding the availability of community service and parole programs, increasing the numbers of judges, and improving access to legal representation, can reduce prison populations in a sustained manner.

These interventions would likely be cost-effective as well, and prevent both injustice and prison-based HIV and TB infection by reducing the number of people unnecessarily jailed or waiting years for trial, especially where key populations are concerned.
He explained that the Malindi Probation and Aftercare Department is charged with the responsibility of generating information for the Courts and Penal Institutions and providing community based offender rehabilitative services within the criminal justice system.

He highlighted that the Probation department encourages collaborative programmes which inform these clients/ offenders on the availability, eligibility requirements, applications procedures and benefits for the non-custodial rehabilitation programmes that cater for:

- Detoxification and Rehabilitation of Drug Users who are in conflict with the law.
- Advocacy, Rights and Community Rehabilitation.
- Reintegration & Income generation of drug users who are in conflict with the law.
DISCUSSANTS PERSPECTIVES

✓ Nearly all participants’ cited inadequate funding as the most significant challenge to their ability to deliver health care. Prison authorities also cited insufficient numbers of qualified medical personnel; others cited poor infrastructure for health, as well as absence of a medical officer trained in TB treatment; others cited inadequate equipment, physical infrastructure, and training of health personnel in TB and HIV management; others cited shortages of health care professionals and lack of appropriate facilities for the management of communicable diseases; additional cited a shortage of medical equipment and drugs; and noted insufficient health staff.

✓ The discussants noted that policing practices involving IDU’s include unjustified arrests, planting of false evidence and extrajudicial syringe confiscations, and often constitute human rights violations. Seemingly, IDU’s experience police violence as ubiquitous, taking on various forms such as beating, unjustified arrests, verbal harassment, and coercion. They reinforced that persistent societal stigma dehumanises PWID, and such stigmatisation facilitates police abuse. To address stigma and overcome the PWID-police adversity, study participants suggested fostering a mutual understanding between the police and public health sectors.

✓ They pointed out that universal access to HIV and TB prevention, treatment, care, and support, cannot be realised if individuals are unable to initiate, or sustain, treatment before sentencing and while detained, and to be effectively referred to treatment programs upon release.

✓ They recommended that the judicial and other criminal justice actors ought to consider reducing the number of key populations in pre-trial detention or detained for minor offenses and instead refer them to compulsory rehabilitation centres. This will greatly reduce the burden on prison systems and to expand health care and ensure continuity of treatment for incoming and released detainees.

✓ Participants agreed that while nearly all prisoners return to the community, many serve multiple short sentences, cycling in and out of prison. Moreover, visitors and prison officers also link prisons to the community, bridging prison health and public health hence community awareness and participation is necessary to address HIV and TB and advance prison and public health.

✓ The discussants agreed that ultimately, the optimal package of tuberculosis and HIV interventions for prisons will need to match the epidemiologic profile of each prison population and will require ongoing evaluation of safety, acceptability, coverage, and effectiveness. Essential to ensuring the implementation and sustained efficacy of this ambitious combination response to tuberculosis control in prisons will be sustained, high-level political support and financing.
The aim of this session was to equip participants with knowledge on the role of regional bodies and laws promulgated by regional bodies in advancing HIV & TB rights.

**Speaker: Michel Ndayikengurukiye, Principal Legal Officer - EAC Secretariat Member.**

He pointed out that while Article 7 (2) and Article 118 on Co-operation in Health of the EAC Treaty highlights on partner states taking joint action towards the prevention and control of communicable and non-communicable diseases and to control pandemics and epidemics of communicable and vector-borne diseases, TB is not explicitly mentioned.

He underlined that TB is however, categorically mentioned in the HIV and AIDS Prevention and Management Act (2012) as well as treatment and protection of vulnerable and most at risk groups.

He stressed that a person applying the EAC Act to interpret it in the light of the letter and spirit of the Treaty, international obligations and objects and purposes of the Act.
He concluded by saying that the EAC has adopted a Protocol on Health (2013) whose purpose is to provide guidance on how to govern regional co-operation on health and related matters among Partner States.

The principal objective of the Protocol on Health is to establish, harmonise and operationalise regional health policies and legal frameworks and mechanisms in order to facilitate and govern regional cooperation on health and related matters among the Partner States.

**Speaker: Maureen Bwisa - Policy & Advocacy Team Leader, The Eastern Africa National Networks of AIDS Service Organisations (EANNANSO)**

She introduced EANNASO as a regional network of national networks of AIDS Service Organisations in 7 Eastern Africa Countries namely: Burundi, Kenya, Rwanda, Tanzania (including Zanzibar), Uganda, Ethiopia, and South Sudan. EANNASO secretariat is located in Arusha, Tanzania.
EANNASO is among the 7 global implementers of the TB Challenge Facility for Civil Society Project Round 7 to be implemented between April 2016 and September 2017 and it is two phased: Community resource mapping and supporting effective CSOs and community organisations engagement in the TB response.

She explained that the EAC Regional Health Sector Strategic Plan (2015 – 2020) will, among others, take joint action towards the prevention and control of communicable and non-communicable disease and to control pandemics and epidemics of communicable and vector-borne diseases.

Similarly the EAC Integrated Health Programme (2016 – 2020) will build on actions, results and lessons of recent and current EAC health programmes particularly those focusing on regional cooperation on SRHR/RMNCAH AND HIV & AIDS, TB.

**Speaker: Annabel Raw – Health Rights Lawyer, SALC**

She explained that the SADC HIV and AIDS Strategic Framework 2010 – 2015 provides a strategic framework for the Southern African Development Community (SADC) response to the HIV and AIDS epidemic.

The framework builds on what has been achieved under the previous Strategic Framework (2003–2007) and establishes strategic objectives and actions of operation for the period 2010–2015. The Strategic Framework was intended to provide guidance to the response to HIV and AIDS, especially to move towards Millennium Development Goal (MDG) 6 and its targets were to halt and begin to reverse the spread of HIV and AIDS by 2015 and achieve, by 2010, universal access to HIV and AIDS treatment for all those who need it.

She indicated that the framework situates the regional response to HIV and AIDS in the context of the five priorities identified in the Maseru Declaration as needing urgent attention. These are: Prevention and social mobilisation, improved access to care, counselling, testing, treatment and support, accelerating development and mitigating the impact of HIV and AIDS, intensifying resource mobilisation and strengthening institutional monitoring and evaluation mechanisms.
She concluded by drawing attention to the suspension of the SADC Tribunal which had the legal authority to deal with individual human rights petitions and that its rulings should be binding over member states, and this has led to serious implications for human rights in the region.

**DISCUSSANTS PERSPECTIVES**

- The participants sought to know the next steps concerning SADC strategic framework 2010 – 2015 which has already elapsed.

  Ms Annabel explained that currently, SADC has a Regional Advocacy Strategy on HIV and AIDS, TB and STIs 2015–2018 to equip the SADC Secretariat and Member State Governments to prepare briefs that will include advocacy outcomes, results and target audiences and partners and specific strategies for the SADC Member State Governments to take forward at country level.

- The participants’ wanted to know if there is any current development of policies on HIV and TB at the regional level since Kenya has made new advancements such as the use of PREP and self-testing kits that can be adopted as a best practice in other sub-Saharan countries.

  Mar. Ndayikengurukiye explained that the EAC has drafted a number of policy and strategy instruments to operationalise Article 118 of the treaty for the establishment of the EAC. Examples of these include: the EAC Health Policy, EAC Health Sector Strategic Plan 2015-2020 and the EAC HIV/AIDS and Sexually Transmitted Infections Strategic Plan 2015-2020.

  He notified the participants that the 1st EAC heads of state summit on investment in health and joint international health sector investors and donors roundtable meeting: 27th to 30th November 2017. The summit and the donor - round table meeting and trade exhibition will provide an opportunity for high level discussions among Partner States, national, regional and international Partners, local investors and other stakeholders aimed at focusing attention on the urgent need for major investments in the health sector.

- The discussants pointed out that there is need to make proportionate the existing regional laws to address inadequate harmonisation and coordination in the areas of disease-specific management guidelines, cross-border referral, disease control across borders as well as inadequate disease surveillance and epidemic preparedness.
The aim of this session was to highlight good practices on working with key populations and guaranteeing access to HIV and TB services by law enforcement officers and health care workers from various jurisdictions. The session will give an opportunity to learn from the panellists and see if these practices they can borrow and replicate when providing services to key populations.

Speaker: Abdalla Kirungu – Law Enforcement Officer, Tanzania

He said that in his line of work, he has realised that due to being criminalised and marginalised, and due to well-founded fear of experiencing problematic interactions with law enforcement and the police, people who use drugs are reluctant and/or unable to access legal justice and/or to report difficulties such as abuse, violence, and discrimination that they may have experienced, and they felt that cannot rely on the police or state to protect them.

He explained that the war on drugs is, in reality, a war on people who use drugs, and a war on the communities in which they live. It is a war that has had appalling impacts upon health, welfare, and human rights. He articulated that law enforcement officers, particularly the police and members of the criminal justice system must be sensitised to the needs and rights of the people who use drugs.
Speaker: Aleksey Ziborov, Law Enforcement Officer – Ukraine

He explained that access to treatments for HIV and drug-resistant Tuberculosis in the country has been an issue of concern. He said that sex work in Ukraine increased with the social and economic upheaval resulting from the collapse of the Soviet Union, a phenomenon common throughout the region. Many sex workers inject drugs, or have clients or sex partners who are injecting drug users. Many drug users exchange sex for drugs or money to support their habit. The overlap between sex work and injecting drugs heightens the risk of HIV transmission (through needle sharing as well as sexual transmission) and exposure to police violence and harassment.

He added that cooperation between law enforcement units, NGOs and public health services has led to administratively centralised and vertically organised, with specialised and distinctly separate health services for HIV/AIDS, tuberculosis, sexually transmitted infections, and substance abuse treatment. Furthermore, people living with HIV/AIDS are guaranteed the right to free medication necessary to treat existing diseases, under Ukraine’s national HIV/AIDS law.

Speaker: Rashid Nyanje – Health Care worker working with key populations in Mombasa County

Shimo la Tewa Prison has undergone major refurbishment and reforms. Currently, there is an in-house medical facility that has added greatly to Prison Service’s ability to serve its population.

There is a prison doctor, who manages the clinic as well as tends to patients, is on site full time, assisted by qualified staff. Moreover, all inmates, as a minimum, undergo a tuberculosis symptom screening on admission to prison.
Likewise, TB surveillance and reporting have been strengthened to promote adherence and defaulting. He noted that there exists special logistic precautions that are required to ensure adherence and continuity of care when prisoners are transferred between prisons and on discharge to the community. Moreover, the prison has partnered with AMREF for provision of nutritional supplements for prisoners on TB treatment.

In addition, there are weak and strained linkages between the national and county health officers since the health function was devolved at the He proposed increased public awareness of the healthcare rights of prisoners that will protect both prisoners and society at large.

**Speaker: Reynaldo Mendes, Medical Officer at Enda Santé, Senegal**

He said that the coverage of the HIV/AIDS and TB programs by the organisation is sufficiently broad and the packet of activities is solid and covers various aspects of the prevention and control of HIV/AIDS and TB, including the prevention of HIV/AIDS and TB, support of treatments; the psychosocial takeover of the co-infection of HIV/AIDS and TB, nutritional support; and the strengthening of the health system. Interventions are also done at night so as to reach key populations such as commercial sex workers. He said that mobile health workers are now using digital testing kits for TB.
DISCUSSANTS PERSPECTIVES

✓ There was consensus that TB should be prioritised in the discussion of core health and social issues around cross border migration. A joint plan of action should be made operational on both sides of the borders. Cross-border interventions will involve all concerned sectors to carry out a situation analysis, identify effective suitable policies and strategies, and designing and implementing appropriate interventions and activities.

✓ The participants’ highlighted that prison health staff are often poorly motivated owing to lack of appropriate healthcare training on TB, and the infectious hazard and stigma of prison work.

✓ It was stressed that prisons in sub-Saharan Africa, there is need for strengthened implementation of conventional tuberculosis control activities, combined with a long-term investment in a broad range of public health interventions, including more up-to-date and sensitive point-of-care tuberculosis diagnostics, combination prevention interventions for HIV, infrastructure upgrades, and improved coordination of healthcare service delivery.
The aim of this session was to highlight how health care workers can ensure that the communities who miss TB diagnosis and treatment can be reached. What is the role of health care workers and law enforcement officers, development partners and activists to ensure that no population is left behind in terms of TB.

**Speaker: Colleen Daniels, Human Rights, Gender & TB/HIV Advisor – Stop TB Partnership (Switzerland)**

She explained that investment in key and vulnerable populations is a vital factor to ending HIV/AIDS and TB and without broadened, evidence-based programs for the key populations, it will not be possible to meet the Sustainable Development Goals (SDG).

She emphasised that we already have at our fingertips tools, including active case finding, improved diagnosis, high-quality treatment (of drug-susceptible and drug-resistant tuberculosis), and preventive therapy but we need to integrate appropriately targeted interventions based on a better understanding of local catalysts of tuberculosis transmission, factors that increase contact rates, infectiousness, and susceptibility at the community level.
She concluded by saying that all stakeholders must therefore develop a high-level framework for deciding how to target the right set of interventions to the right populations, for instance those who engage in transactional sex (sex for fish, sex for water, sex for motorbike rides etc.), depending on the relative contributions of each catalyst and the locally available capacity, a ‘one size fits all’ approach is no longer viable.

**Speaker: Nthabiseng Mokoena – ARASA**

Nthabiseng said that the AIDS and Rights Alliance for Southern Africa (ARASA) and UNDP Regional Service Centre for Africa, under the Africa Regional Grant on HIV: Removing Legal Barriers will host the second Africa Regional Dialogue on HIV, TB and the Law on 3-4 August 2017 in Johannesburg, South Africa.

The second Africa Regional Dialogue will bring together 140 government and civil society participants from across Africa to discuss progress on the implementation of the findings and recommendations of the Commission on HIV and the Law in the region, highlight issues and ongoing challenges and make strategic suggestions and recommendations on the way forward.
The speaker stressed that services for key populations are frequently best delivered by those same key populations. Peer outreach for people who inject drugs, for example, or HIV awareness campaigns targeting sex workers that are delivered by sex workers. It is crucial to work with implementers of programs to be sure that they are tailored to the needs of different key populations.

**DISSCUSSANTS PERSPECTIVE**

- The participants underscored the changing epidemiology of tuberculosis requiring critical to scale-up of screening and preventive therapy programs to other high risk populations such as those who are diabetic, those with leukaemia and lymphomas as well as street children, people with disabilities and migrant truck drivers. Food handlers may also be an important group to screen for tuberculosis.

- They agreed that it is essential to devolve TB treatment to local/county public health officials who are able to identify groups of persons in the community among whom tuberculosis and transmission of infection occur. This will require collecting and analysing data (e.g., residence, occupation, and indicators of socioeconomic status) on newly reported cases that are not now routinely collected and/or analysed. These data will enable health departments to target screening and treatment programs to locally defined high-risk populations and areas.

- The discussants said it is key for countries to assess their specific situations, taking into account current population sizes and reviewing current coverage levels and the quality of programmes. It is also important to assess and, where possible, to address social and legal barriers to access and to make progress as country-specific circumstances allow.
SESSION 8: ACTION PLANNING

The session aimed at helping participants to discuss ideas and formulate actionable steps that they would take forward to guarantee access to HIV and TB services for key populations in their various countries.

Speaker: Allan Maleche – Executive Director, KELIN

He explained that previous programs did not integrate local epidemiology and sociocultural factors when allocating resources and advised the participants to develop feasible HIV/AIDS and TB programs that will take into account the needs of key populations, children and their families and address the associated logistical and financial gaps.

He emphasised that the programs need to ensure scaling up and improvement of advocacy, communication, and social mobilisation collaborating activities as well as more ambitious planning at the community level, so as to involve key populations especially those with MDR or extensively drug-resistant (XDR) TB.
The following are the action plans, developed per country:

**KENYA**

<table>
<thead>
<tr>
<th>What do you want to influence or change?</th>
<th>What actions are needed to achieve change?</th>
<th>Who do you need to target?</th>
<th>When will the actions happen? What do you now know now about the timeline?</th>
<th>Who will take the actions?</th>
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</thead>
</table>
| Establish a Country coordinating mechanisms with inclusion and representation of the key population. | • Put in place Leadership  
• Develop terms of reference of the country coordinating mechanism.  
• Develop communication strategies  
• Develop media information kit | • Partners; CSO, GOK, MEDIA, COMMUNITY, Key Population  
• Opposition;  
• Nationals; poor funding  
• Legislation: Rejecting reforms  
• Community; Culture and religious | • Leadership: Immediate  
• TOR: 1 Month  
• Communication strategy; 2 months | • Teams represented will elect leadership  
• TWG that will develop the TOR  
• TWG on communication | • GOK,  
• KELIN  
• AMREF,  
• UNODC  
• KMA, |
| Integration of TB within existing mechanisms (PMTCT, SRHR, Global fund) | • In Service delivery; Include TB as part of the Global Fund minimum harm reduction package  
• Supply chain system  
• Mobilisation of resources | • Partners; CSO, GOVN, MEDIA, COMMUNITY, PARTNERS, Donors,  
• Oppose;  
• 1. Healthcare workers  
• 2. Constrained health infrastructure | • Service delivery: 1 year  
• Supply chain; 1-2 years  
• Mobilisation of resources: 6 Months to 1 year | • AMREF, STOP TB partnership, NACC, KMA  
• Government  
• CSO, National Government, County 1. governments, | • Government, AMREF, UNODC, WHO, UNFP, KMA, UNICEF, CSO, |
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</table>
| Decriminalisation and reclassification of punitive and petty offenses | • Tackling health inequalities e.g. poverty, overcrowding, poor housing etc.  
• Private Sector Partnership  
• Advocacy working closely with the KP community  
• Lobbying  
• Sensitisation  
• Public interest litigation  
• Healthcare worker Rights | 3. Government because of Resource constrains  
4. Community  
5. Legislators  
• Legislators  
• Judiciary  
• Public  
• CSO  
• Healthcare workers  
• Administrative of justice officers (Ombudsman, IPOA, KNHRC) | Target:  
• TB Caucus  
• KNHRC,  
• Medical Bodies,  
• CSO,  
• Opposition:  
• National and county government | • Parliament  
• Senate  
• MOH  
• County governments | • Judiciary  
• KNHRC  
• Government  
• CSO |
# Tanzania

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</table>
| The Act establishing the National Organs responsible for HIV response, i.e. TACAIDS and ZAC, to expand the services to include TB and Harm Reduction services | • Involvement of Key stakeholders  
• Sensitisation of the Decision makers on integrating HIV, TB and Harm reduction | • Allies:  
• Responsible sector ministries and agencies i.e. Prime minister’s office, Ministry of Home affairs, Ministry of Health, Ministry of finance.  
• UN Agencies and DPs  
• CSO’s  
• Private sectors  
• Opposes:  
• Ministry of Constitution and legal affairs  
• Political manifestos  
• Reform processes | 3-5 years | • Responsible Ministries  
• AGC  
• Law Reform Commission | • DPs, UN agencies  
• Private Sector |
<p>| HIV laws/Act to be revised to include issues related to Key populations, TB and Harm Reduction | | | | | |</p>
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</thead>
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<tr>
<td>To emphasise to CCM members to put more efforts on TB, KP's and Harm Reduction</td>
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<tr>
<td>CCM to have a representative from the law enforcement officer (ministry of home affairs) to respond to various issues hindering HIV, TB and key populations rights.</td>
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</table>
| Engagement with the government in policy making and legislative drafting and collaboration with HOMAL SEXUALITY | Involvement with the legislature, Executive, traditional leaders to create political will for legal reform | • Government  
• CSOs  
• Local  
• NGOs  
• Law commission MPs  
• Courts.  
• OPP  
• Religious leaders  
• Chiefs and other law enforcers | 12 Months | CSOs, Ministry of Justice, Law Commission | • cooperating partners |
| Engage and collaborate with government CSOs in reviewing VAGRANCY LAWS | Lobbying and advocating on repealing of vagrancy laws | • CSOs, KP’s, Malawi Law Society, Courts | 12 Months | CSOs  
Law society  
Courts | • cooperating partners |
| Social protection – developing and integrated service centre that takes cognizance of human rights approach on TB and HIV | Creating follow up component of TB and HIV and AIDS treatment within the criminal justice system. Maximisation of case detection rate on TB for FSW and MSM | • Ministry of Health, Law enforcers, people in conflict with the law  
(KP’s) | 6 months and on going | Ministry of Health, Police, Prison | • CEDEP, PA-KACHEHERE, CLAIR, UNFPA and cooperating partners |
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<tbody>
<tr>
<td>Sensitisation of law enforcers officers, judicial officers and the community on the existence of KPs</td>
<td>Law enforcers</td>
<td>CSOs, Local NGOs, Law commission, MPs, Courts. Opposition: Govern. Religious leaders, chiefs, some law enforcers</td>
<td>3 Months and on going</td>
<td>CSOs, Law enforcers</td>
<td>cooperating partners</td>
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**UGANDA**

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</table>
| National HIV/AIDS Strategic plan midterm review of the plan is in December 2017 | Propose strategies for inclusion for human rights and TB in key populations | • M.O.H  
• Civil Society  
• UAC  
• No Opposition | December 2017 | Technical working Group | • GF  
• SALC  
• KELIN  
• UGANET  
• ARASA  
• STOP TB  
• WHO  
• MOH |
| Improved TB diagnosis, treatment, care, support linkage and follow-up in detention centre settings | • NTBLP to allocate GeneXpert to 10 regional facilities For Prisons  
• 4 for UPF and UPDF respectively | • Program Manager NTBLP  
• Regional Prisons Health Coordinators | September 2017 | • Prisons Health Services  
• M.O.H  
• UPF |
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</thead>
<tbody>
<tr>
<td>Multi-sectoral coordination</td>
<td>Formation and activation of a national working group</td>
<td>UAC</td>
<td>20th July</td>
<td>Dr Zephar</td>
<td></td>
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**NIGERIA**

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</table>
| Understand gender and legal environment for TB in Nigeria | Gender and Legal Environment Assessment of TB | • Legal System  
• Health Workers  
• TB Patient Groups  
• Civil Society Groups  
• Vulnerable Populations | 3 Months | National Task Team of the National TB and Leprosy control | • ARASA  
• KELIN  
• Stop TB Partnership |
| Increase TB detection rate in the country | • Scale up TB screening centres  
• Strengthen TB screening services in prisons IDP camps and other vulnerable population | • Prison service  
• Ministry of Health  
• IDP  
• Vulnerable Populations | 6 Months | Federal Ministry of Health (TB / Leprosy Control Program  
• Nigeria Prisons Service | Stop TB Partnership  
WHO  
USG |
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</table>
| • Strengthen HIV/TB collaboration in the country. | Integrate TB community prevention activities into all HIV interventions | • Ministry of Health  
• NACA  
• Civil Society Groups  
• Ministry Of Justice | Immediate | • NACA  
• Ministry of Health/NA-SCP  
• Parliament  
• Civil Society Groups | • UNDP  
• Stop Tb Partnership  
• UNAIDS  
• USG |

**SENÉGAL, SEYCHELLES, CÔTE D’IVOIRE**

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<th>Who will take the action?</th>
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</table>
| Influencer l’intégration des structures de santé pénitencières au ministère de la santé | • Organiser un atelier de plaidoyer regroupant les différents acteurs  
• Mettre en place un groupe de travail impliquant les msa, justice et la commission sante des parlementaires | • Medecin chef administration pénitenciare  
• Coordonateurs de programmes  
• Opposition : ministere de la justice | 2ème semestre 2017 | • Medecin chef administration pénitenciare | • Initiative 5%  
• ou autres |
<table>
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<tr>
<th>What do you want to influence</th>
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<tbody>
<tr>
<td>Signer une convention entre msas et ministere de la justice</td>
<td>Mettre en place un groupe de travail impliquant les differents programmes (vih tb hb ...)</td>
<td>Cnls</td>
<td>4 ème trim 2017</td>
<td>Cnls - pnt</td>
<td></td>
</tr>
<tr>
<td>Reviser la loi sur le vih</td>
<td>• Mettre en place un groupe de reflexion impliquant les juristes, les parlementaires, pvvih, populations cles, societe civile ; • Organiser des ateliers de mises a jour</td>
<td>Cnls</td>
<td>2018</td>
<td>Cnls</td>
<td>Global fund</td>
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**ZAMBIA**

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<th>Who do you need to target?</th>
<th>When will the actions happen? What do you now know about the timeline?</th>
<th>Who will take the actions?</th>
<th>Where can you turn to for technical assistance or support?</th>
</tr>
</thead>
</table>
| For example, in your country’s:         | Sensitisation on KP from a human rights perspective. | • Legislatures  
• Health Providers, CSOs, KPs  
• FBOs, The Church & MoCs | Within the next 8 weeks as parliaments begins to sit next week | MoHA working with CAPAH | UNDP & UNODC |
| Laws                                   |                                          |                           |                                                                      |                          |                                                                 |
| Justice System                         | Engage key stakeholders in the Justice System | • The Judiciary  
• Police  
• Immigration  
• DEC  
• MoH & MoGE.  
• MoI, CSOs, CPs  
• FBOs | Within the next 4 weeks as preparation are in place. | MoH & MoJ | CDC & GIZ |
| Service Delivery                       | Equipment, Facilities, Attitudes         | • Health Care Providers, Police Officers, Inmates & Correctional Officers  
• CPs, GRZ | Within the next 8 weeks | MoHA | CDC and other CPs |
<table>
<thead>
<tr>
<th>What do you want to influence or change?</th>
<th>What actions are needed to achieve change?</th>
<th>Who do you need to target?</th>
<th>When will the actions happen?</th>
<th>Who will take the actions?</th>
<th>Where can you turn to for technical assistance or support?</th>
</tr>
</thead>
</table>
| For example, in your country’s:        | Provide HIV testing, TB screening and case management to MARPS and other vulnerable groups. | • Who will support you in this effort?  
• Who might oppose you (allies and foes)? | Timeframe.  
Starting the month of August 2017 and ongoing. | Ministry of Health and health related NGOs,  
National AIDS Council. | Support  
National AIDS Control Program.  
National AIDS Council. |
|                                        | Train laboratory technician and other health service providers in HIV rapid testing procedures and sputum screening | Target group  
PWUD, Inmates, Prison Staff. |                                         |                                         |                             |
|                                        |                                         |                                         | Minimy of  
Health,  
Ministry of Internal Affairs and Prison Authority.  
Office of the Secretary of State for Drugs Control.  
Non-Governmental Organisations |                             |                             |
CLOSING REMARKS BY HON. EMMANUEL DAVID OMBUGADO, MEMBER OF PARLIAMENT – NATIONAL ASSEMBLY, NIGERIA

He extended gratitude to all the participant for actively participating in the workshop and to KELIN for successfully organizing the regional workshop. He said that there is need for urgent in-country consultations and consensus building meetings with key national TB and HIV stakeholders, including government officials, cultural leaders, civil society organisations, donors, and most importantly, individuals and communities affected by HIV and AIDS and TB to get support for the planned activities and to accelerate the planning process.

He stressed that getting the support of political leaders, religious leaders and other influential figures in society can help to raise awareness of, and strengthen global political commitment to, HIV and TB prevention as well as domesticate treaties on the same. However, this must be followed by strengthened financial commitment. He said that the Nairobi Strategy should continue to be live and serve as a source of information for other countries planning process. He encouraged the countries present to use this strategy to develop their plans and enhance discussions and experience sharing during the planning process.
APPENDICES

Appendix 1: Concept Note

1.0 Introduction and Background

TB Kills 1.4 million people every year and is the number one killer opportunis-
tic infection amongst persons living with HIV. This is largely due to inadequate
programmatic and service delivery issues including: inappropriate or inade-
quate drug regimens or difficulties in adhering to treatment.

Other factors impacting the control of TB are: antiquated treatments and regi-
ments, a lack of rollout of new diagnostic tools, and a large proportion of people
with active TB disease who are missed by health systems. Untreated cases of TB
are detrimental to the physical and financial wellbeing of the people with the
disease and to their families.

Current efforts to combat TB are further challenged by the rise of drug-resistant
TB. Although still comprising a relatively small proportion of all people with
active TB, drug-resistant TB is more difficult and expensive to diagnose, treat
and provide care and support. The longer treatment that often takes 1-2 years
and more side effects of the treatment contribute to high treatment disruptions
resulting in lower treatment success rates than non-resistant TB and leading to
continued and amplified drug resistant mortality.

Many of the 4.3 million active TB cases currently missed by public health sys-
tems every year are likely to be disproportionately concentrated among individ-
uals who are at higher risks of latent TB infection than the general population
due to their current physical conditions, living and working environments and
their legal and social standing within society.

Criminalised and socially marginalised groups present a real challenge to cur-
rent HIV and TB Services across the world. TB services often assume all indi-
viduals with TB are no different from the general population in that they can
recognise TB symptoms and present themselves on their own to the largely
passive health services. This ignores the social, financial, logistical, legal and
other human rights barriers that prevent these individuals from accessing TB
services.
2.0 TB AND KEY POPULATIONS

Environmental factors, specifically restrictive laws and policies, have a profound impact on Health-seeking behaviour among vulnerable populations. When discussing barriers to TB diagnosis and treatment among key populations, the issue of criminalisation should take precedence.

Despite recommendations of multiple international bodies (including WHO, UNDP, UNAIDS, UNHCR, and UN Women) calling for a revision of punitive laws that affect key populations in order to reverse their negative impact on health, human rights and development, countries continue to institute harsh punishments for key populations.

In addition to incarcerating a disproportionate amount of key populations in Africa and around the world thereby subjecting these populations to increased risk of HIV, HCV, and TB or MDR-TB, and treatment delays and interruptions, punitive laws and criminalisation also lead to complete disregard for the human rights of key populations, wide spread harassment and violence by police, and the reinforcement of societal stigma. Both in police lock-ups and in health settings, criminalisation translates into discrimination against key populations, denial of care and treatment, and other practices that can be characterised as cruel, inhumane and degrading.

The Global Plan to End TB outlines the following targets to be achieved by 2020, or 2025 at the latest. The Plan refers to people who are vulnerable, underserved or at risk of contracting TB and provides models for investment packages that will allow different countries to achieve the 90-(90)-90 targets. To achieve these targets the Stop TB Partnership, KELIN and the International Human Rights Clinic, University of Chicago Law School formed the TB and Human Rights Consortium and drafted the Nairobi Strategy to develop and implement a human rights-based approach to TB.

Key in the Nairobi strategy is the need for the expansion of the capacity of law enforcement officers and health care workers in combating TB. There is need for these two groups to incorporate the rights based approach when providing services so as to reduce stigma and discrimination which are key barriers to accessing HIV and TB services for key populations.
3.0 JUSTIFICATION

From the above, it is clear that human rights violations and the failure to fulfil human rights obligations increase key populations vulnerability to contracting TB and reduce access to diagnostic, prevention and treatment services. People affected by TB usually suffer a double burden: the impact of the disease as well as the consequential loss of other rights. For key populations, due to additional stigmatisation the burden is in fact triple.

A rights-based approach to TB is founded on respect for the dignity and autonomy of people affected by TB. It articulates and protects individual freedoms and entitlements, and is built on governments’ obligations to respect, protect and fulfil the right to health.

It is in this regard that KELIN in partnership with ARASA, ENDA Santé, SALC and UNDP regional office with support from The Global Fund seeks to conduct a two (2) days capacity strengthening forum for law enforcement officers and health care workers. The forum will be premised on the crucial role that law enforcement officers and healthcare workers play in supporting rights-based responses to HIV and TB in the region and will provide an opportunity for these stakeholders to share experiences and enhance their understanding of the link between HIV, TB, Human rights and the Law.

4.0 OBJECTIVES

The key objectives of this meeting include:

• To enhance the understanding of the linkages between HIV, TB, Human rights and the law as they affect key populations,

• To sensitise stakeholders on the rights based approach to providing health care services to key populations.

• To foster regional and in-country partnerships for increased advocacy and lobbying for removal of legal barriers which impede access to health care by key populations.
5.0 EXPECTED OUTPUTS

- Development of action plan by participating countries to follow up on the recommendations made at the forum
- Development and/or strengthening of regional and national platforms or networks to address the legal barriers that are impeding access to services by key populations

6.0 METHODOLOGY

The forum will involve presentations from experts, panel discussions and group discussions amongst participants. Persons living with HIV and/or affected by TB will also be part of the resource persons.

7.0 PARTICIPANTS

A total of 50 participants are expected to participate in this forum. The participants will be law enforcement officers and health care workers and representatives of Key Populations from Botswana, Cote d’Ivoire, Kenya, Malawi, Nigeria, Senegal, Seychelles, Tanzania, Uganda and Zambia.

8.0 DATES AND VENUE

The two days forum will be held at the Sarova White Sands, Beach Resort and Spa in Mombasa, Kenya on 7-8 June, 2017.
Appendix 2: Sessions Description

<table>
<thead>
<tr>
<th>TIME</th>
<th>ACTIVITY</th>
<th>FACILITATOR</th>
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<tbody>
<tr>
<td>8.00 – 8.30 am</td>
<td>Registration</td>
<td>KELIN</td>
</tr>
<tr>
<td>8.30 - 9.00 am</td>
<td>Introduction</td>
<td>Ted Wandera KELIN</td>
</tr>
<tr>
<td>9.15 - 9.30 am</td>
<td>Welcoming remarks, objectives and conceptualisation of the workshop.</td>
<td>Allan Maleche Executive Director KELIN</td>
</tr>
<tr>
<td>9.30 - 10.00 am</td>
<td><strong>KEYNOTE ADDRESS</strong></td>
<td>• John Njenga Key Population and TB Survivor</td>
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<td></td>
<td></td>
<td>• George Magwende Head of Prisons Zambia</td>
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<td></td>
<td></td>
<td>• Dr Lucica Ditiu Executive Director Stop TB Partnership (Switzerland) (Via Video)</td>
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<tr>
<td>10.00 – 10.15 am</td>
<td>Video Session: The Journey of the TB is not a crime case in Kenya</td>
<td>Vincent Obwanda KELIN</td>
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<tr>
<td>10.15 – 10.40 am</td>
<td><strong>SESSION ONE</strong></td>
<td>Chair: Dr Mabumba Principal Medical Officer National</td>
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<td></td>
<td>Community Experiences on access to TB Services</td>
<td><strong>TB Program Uganda</strong></td>
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<td></td>
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<td>• Apollo Nderitu TB Survivor Kenya</td>
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<td></td>
<td>• Karabo Rafube TB Survivor South Africa</td>
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<tr>
<td>10.40 am – 11.00 am</td>
<td><strong>HEALTH BREAK AND GROUP PHOTO</strong></td>
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<tr>
<td>11.00 am – 12.00 pm</td>
<td><strong>SESSION TWO</strong> The Science of TB: Key Populations at the core of TB Interventions.</td>
<td>Chair: Deena Patel (UNDP)</td>
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<td>• Colleen Daniels, Human Rights, Gender &amp; TB/</td>
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<td></td>
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<td>• HIV Advisor, Stop TB Partnership (Switzerland)</td>
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<td>• Dr. Emperor Ubochioma Senior Medical Officer</td>
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<td>• TB and HIV Federal Ministry of Health Nigeria</td>
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<tr>
<td>12.00 - 12.55 pm</td>
<td><strong>SESSION THREE</strong></td>
<td>Chair: Mr. Miraji Mambo Legal Officer TACAIDS</td>
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<td></td>
<td>HIV TB and Key Populations: The Role of the Law</td>
<td>• Allan Maleche KELIN</td>
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<td>• Annabel Raw SALC</td>
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<td>• Timothy Wafula KELIN</td>
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<tr>
<td>12.55 – 1.00 pm</td>
<td>Closing Reflections</td>
<td>Allan Maleche</td>
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<tr>
<td>1:00 - 2:00 pm</td>
<td><strong>LUNCH</strong></td>
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<td>2.00 - 5.00 pm</td>
<td>Field Visit</td>
<td>• Lugad Abila Reach out Centre Trust</td>
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<td>Group A- Visit to Shimo La Tewa Prison</td>
<td>• Ted Wandera KELIN</td>
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<td>Group B- Visit to Clinic providing TB Services to Key Populations</td>
<td>• Vincent Obwanda KELIN</td>
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<td></td>
<td>Group C- Visit to Harm Reduction Site (Go Down)</td>
<td>• Timothy Wafula KELIN</td>
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<tr>
<td>5:00 PM</td>
<td><strong>TEA AND END OF DAY</strong></td>
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<tr>
<td>TIME</td>
<td>ACTIVITY</td>
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<tr>
<td>8.00 - 8.30 am</td>
<td>Registration</td>
<td>KELIN</td>
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<tr>
<td>8.30 - 9:00 am</td>
<td>Recap of Day 1</td>
<td>Vincent Obwanda (KELIN)</td>
</tr>
<tr>
<td>9:00 – 9:15 am</td>
<td><strong>KEYNOTE ADDRESS</strong></td>
<td>Justice Mumbi Ngugi <em>Presiding Judge High Court of Kenya at Kericho</em></td>
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<tr>
<td>9.15 – 9:30 am</td>
<td>Reflections on Field Visit</td>
<td>Rtd Justice Mavisi</td>
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</table>
| 9.30 – 10.00 am       | **SESSION FOUR**                                                        | Chair: Esther Kamede *UGANET*  
• Hon. Yussuf Abdallah Shikanda Senior Resident Magistrate  
• Mr. Dennis Mwaniki Probation Officer Malindi               |
| 10.00 – 10.45 am      | **SESSION FIVE**                                                        | Chair: Bwijo *UNDP*  
• EAC Secretariat Member  
• Maureen Bwisa EANNASO  
• Annabel Raw SALC                                           |
| 10.45 – 11.00 am      | HEALTH BREAK                                                            | Chair: Papa Abdoulaye Deme *UNDP*                        |
| 11.00 am – 12.00 pm   | **SESSION SIX**                                                         | Chair: Abdalla Kirungu *Law Enforcement Tanzania*  
• Aleksey Ziborov *Law Enforcement Ukraine*  
• Rashid Nyanje *Health Care worker working with key populations Mombasa county*  
• Dr. Reinaldo Mendez *Medical Officer Enda Sante*            |
| 12:00 - 1:00 pm       | **SESSION SEVEN**: How do we find these missing populations in the fight against TB? | Chair: Colleen Daniels *Human Rights, Gender & TB/HIV Advisor, Stop TB Partnership (Switzerland)*  
• Nthabiseng Mokoena *ARASA*                                  |
| 1.00 PM – 2.00 PM      | LUNCH BREAK                                                             |                                                          |
| 2:00 - 2:30 pm        | **SESSION EIGHT**                                                       | Allan Maleche *KELIN*                                    |
| 2.30 - 3.15 pm        | Presentation of Action Plans                                            | Rtd Justice Mavisi                                       |
| 3:15 – 3.40 pm        | **SESSION NINE**: Closing Reflections                                    | Rtd Justice Mavisi                                       |
| 4:00 - 4:30 pm        | Closing Remarks                                                          | Hon. Emanuel David Ombugado Member of Parliament National Assembly Nigeria |
| 4:30 PM               | TEA AND END OF MEETING                                                  |                                                          |