STATE OF HEALTHCARE FOR PRISONERS IN KENYA
A SURVEY REPORT

Abstract

Kenya Prison Service (KPS) Directorate of Medical services is responsible for providing health care services to approximately 58,000 inmates housed in 118 correctional facilities across Kenya. This includes emergency and urgent care and care needed to prevent further deterioration of an inmate’s condition. In 2017, KNCHR undertook a monitoring exercise in 75 prisons to evaluate the adequacy of the KPS medical services and the effectiveness of its medical services. This was against a backdrop of the nationwide doctors strike vis-à-vis the vulnerable position that inmates already find themselves.

Directorate of Research, Advocacy & Outreach, Reforms & Accountability Division.

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ACKNOWLEDGEMENT

This report is as a result of the dedication and commitment by the teams responsible for the delivery of penal reforms. KNCHR would like to express sincere gratitude to all individuals who contributed to the successful production of this publication. The Commission would specifically like to recognize the Commissioner General of prisons, the Officers in charge of all the prison facilities that were visited during the survey, the various Kenya Prison Staff and all prisoners who participated in the focused group discussions and interviews.

EXECUTIVE SUMMARY

Right to health is a Socio-Economic right that every person is entitled to as enshrined under the Constitution of Kenya.\(^1\) It is a progressive right and the constitution obligates the state to put in place affirmative action programs to ensure that minorities and marginalized groups have reasonable access to health services. the state has the obligation to ensure that this right is achieved to the highest attainable standard and if the state claims that it does not have resources to implement the right, then it is its responsibility to show that resources are unavailable and that in allocating resources it shall give priority to ensure the widest possible enjoyment of the right.\(^2\)

Healthcare in prison is specifically important due to a variety of reasons; being isolated from society, prisoners are practically deprived of health services they used to benefit from prior to their imprisonment. At the same time, studies show that the rates of communicable diseases in prison are much higher than in the free society. Poor living conditions and overcrowding, typical for many prisons, also contribute to this situation.\(^3\). Kenya is yet to attain the realization of the highest attainable standards of health as provided for in the Constitution. The health care industry in Kenya faces numerous challenges including disproportional funding allocation and lack of sufficient medical personnel and equipment. Under the circumstances, prisoners stand a high chance of experiencing double marginalization and lack of prioritization to their needs.

It is in this regard therefore that the Commission, pursuant to its constitutional and statutory mandate of promotion and protection of human rights embarked on a survey to measure the compliance to the right to health in Kenyan prisons. Factors that were taken into consideration by the commission included the following; the physical proximity of services to the prisoners and its quality, equality and non-discrimination in services with inclusion and protection of the vulnerable groups and the overall prison environment including sanitation and nutrition.

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\(^1\) Article 43(1)(a)
\(^2\) Minister of Heath & others v Treatment Action Campaign and Others (2002)
\(^3\) Promoting fair and effective criminal justice, Penal Reform International also available online at https://www.penalreform.org/priorities/prison-conditions/key-facts/health/
The survey was conducted in 73 prisons spread across 40 counties with geographical, gender and security levels of the facilities as major determinants of the survey population sample. The survey findings indicate that Kenya still falls short of international, regional and national standards and principles with relation to accessible and quality medical health care services in penal institutions. The right to health of inmates vis-à-vis the security consideration was an important element that was observed in the penal institutions inspected. The vulnerable groups in prisons including persons with disabilities, women, children accompanying their mothers, HIV positive prisoners face unique challenges that need a holistic approach and planning from the duty bearers. Their unique vulnerabilities need to be mainstreamed in frameworks and policies in order to reasonably accommodate them in prisons. Data, specifically, in relation to prisoners with disability was hugely lacking which in turn affects their overall enjoyment of their rights.

The survey however noted a big improvement in terms of sanitation and hygiene in 90% of the sampled prisons and the Commission takes this opportunity to laud the Kenya Prisons Services through their respective Officers in Charge. The survey findings also highlighted a structured and adequate management of prisoners with TB and HIV especially in terms of drug allocation, dietary modifications and HIV Testing and Counselling that was available in 100% of the survey prison sample. It is the hope of the Commission that this targeted and coordinated approach to these category of prisoners shall be extended to other ailments and conditions including communicable diseases.

Inadequate funding was cited as a reason for majority of the challenges prisons in Kenya face in the quest to provide health care for the inmates. The Commission hence makes a raft of recommendations to the relevant state organs on how to address this issue including prioritization and adequate allocation of funds to the Kenya Prisons Services budgetary requirements on health in partnerships with non-state agencies and development partners on providing sustainable and durable solutions in line with the Human Rights Based Approach.
The Commission remains steadfast in its quest for advancing the rights of prisoners and hopes that the findings and recommendations contained herein will impact holistic reforms of our penal institutions.
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<tr>
<th>Abbreviation</th>
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<tr>
<td>CCC</td>
<td>Comprehensive Care Centre</td>
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<td>CO</td>
<td>Clinical Officer</td>
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<td>COK</td>
<td>Constitution of Kenya</td>
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<td>Criminal Procedure Code</td>
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<td>CRPD</td>
<td>Convention on the Rights of Persons with Disabilities</td>
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<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<td>HTC</td>
<td>HIV Testing and Counselling</td>
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<td>ICCPR</td>
<td>International Covenant on Civil and Political Rights</td>
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<td>ICESCR</td>
<td>International Convention on Economic, Social and Cultural Rights</td>
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<td>KPS</td>
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<td>OIC</td>
<td>Officer in Charge</td>
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<td>Power of Mercy Committee</td>
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<td>PWDS</td>
<td>Persons with Disabilities</td>
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<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<td>UDHR</td>
<td>Universal Declaration on Human Rights</td>
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<tr>
<td>UNSMR</td>
<td>United Nations Standard Minimum Rules</td>
</tr>
</tbody>
</table>
# TABLE OF CONTENTS

## CHAPTER 1 : INTRODUCTION

1.1 The Right to Health in Prisons ................................................................. 2
1.2 Survey Objectives .................................................................................. 4
1.3 Survey Setting ....................................................................................... 4
1.4 Methodology of the Survey ................................................................. 5
1.5 Study Population and Sampling ......................................................... 5

## CHAPTER 2 : NORMATIVE FRAMEWORK

2.1 International Human Rights Instruments ............................................. 6
2.2 Regional Framework ........................................................................... 8
2.3 National Framework .......................................................................... 9
2.3.1 The Constitution of Kenya ............................................................ 9
2.3.2 The Prisons’ Act CAP 90 and the Borstal Institutions Act CAP 92 10
2.3.3 Persons Deprived of Liberty Act CAP .......................................... 11

## CHAPTER 3 : FINDINGS

3.1 Prison Health Services ....................................................................... 12
3.1.1 Availability of a Medical Facility .................................................. 13
3.1.2 Security vis-à-vis access to medical services ................................. 19
3.2 Quality of Medical Care ..................................................................... 21
3.2.1 Medical Examination Upon Entry .............................................. 21
3.2.2 Inpatient Treatment ..................................................................... 24
3.2.3 Communicable Diseases ............................................................... 25
3.2.4 Records and Management of Drugs for Inmates .......................... 29
3.2.5 Regular Medical Examinations .................................................... 30
3.3 Treatment of Vulnerable Groups in Prisons ......................................... 32
3.3.1 Management of Inmates with HIV ............................................ 32
3.3.2 Access to Reproductive Health Care for Female Inmates .......... 33
3.3.3 Inmates With Disabilities ............................................................. 37
3.3.4 Rehabilitation of Drug Addicts .................................................... 40
3.4 Sanitary Conditions ............................................................................ 42
3.4.1 Waste Disposal .......................................................................... 46
3.5 Food and Nutrition ........................................................................... 47

## CHAPTER 4 : CONCLUSION AND RECOMMENDATIONS

4.1 Conclusion ......................................................................................... 51
4.2 Challenges ......................................................................................... 52
4.3 Recommendations / Action Points .................................................... 53

## CHAPTER 5 : ANNEXURES

5.1 Annexure 1: List of Prisons Visited ..................................................... 57
5.2 Annexure 2: Assessment Tool for Inspection of Right to Healthcare in Places of Detention 59
The Kenya National Commission on Human Rights (KNCHR) is a National Human Rights Institution (NHRI) that is established under Article 59 of the Constitution of Kenya. It is operationalized by the Kenya National Commission on Human Rights Act of 2011 (revised 2012) with the core mandate of promoting and protecting human rights in Kenya. The KNCHR’s mandate was further enhanced by the Prevention of Torture Act (POTA) of 2017 that seeks to promote and protect the right to freedom from torture, cruel, inhuman and degrading treatment.

In addition, the KNCHR is an “A” status NHRI accredited by the Global Alliance of National Human Rights Institutions (GANHRI) having met the requisite international standards of effectively and efficiently carrying out its mandate. As a result of this “A status”, KNCHR has audience in regional and international human rights treaty bodies and charter-based mechanisms.

Section 8 (c) of the KNCHR Act provides that the Commission shall monitor, investigate and report on the observance of human rights in all spheres of life in the Republic. In the exercise of this function, the Commission engages in a number of activities including inspection of places of detention and monitoring various aspects of human rights in places of detention. It also takes the necessary steps to secure appropriate redress for violations of human rights.

Under the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment the KNCHR is designated as the National Preventive Mechanism (NPM). This mechanism involves a system of regular, unannounced, pro-active visits to document and respond to human rights violations in places of detention.
1.1 The Right to Health in Prisons

The right to conditions “adequate for the health and well-being” of all is recognized in the Universal Declaration of Human Rights.\(^4\) It must be recognized that detention does not derogate the rights and fundamental freedoms all human beings are entitled to. Other than limitations necessary for the condition of detention, no other limitation to the rights of a detainee is permissible. The ICCPR specifically provides that “all persons deprived of their liberty should be treated with humanity and with respect for the inherent dignity of the human person.”\(^5\)

Healthcare in prisons is also closely linked to public health in general. As noted by the WHO, prison populations usually contain a high prevalence of people with serious and often life-threatening conditions who will return to the community, carrying back with them new diseases and untreated conditions that may pose a threat to community health.\(^6\) The spread of infectious diseases is a threat to the health of not only the prisoners and the staff but also to the community at large.\(^7\) Therefore, when a state deprives people of their liberty, it takes on the responsibility to look after their health so that prisoners do not leave prison in a worse condition than when they entered.

It is trite knowledge that Kenyan prisons do not have the best containment conditions\(^8\) and are perennially plagued with the problem of congestion. This challenge of overcrowding in turn does affect other human right entitlements of prisoners such as dietary allocation and quantity, access to clean and adequate water, sanitation, prison uniforms, healthcare and recreation among others.

In spite of the available robust legal protection mechanisms at both the international and domestic level, being an inmate of Kenyan prisons can still be considered a health hazard: the health status

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\(^4\) Article 25, UDHR.
\(^5\) Article 10, ICCPR.
\(^6\) WHO (2007) Health in Prisons: A WHO guide to the essential in prisons health
\(^8\) See KNCHR Reports on prison conditions (Annual Report for the 2009/2010 Financial Year at Pg. 29); See also E Ondieki, Inside Kenya's Criminal Justice System: Only the Tough Survive, Sunday Nation (Sunday, January 29 2017), also available online at <http://www.nation.co.ke/lifestyle/lifestyle/Inside-Kenya-tough-Prisons-/1214-3790978-i26ds8z/index.html>. 
of prisoners is generally lower than that of the rest of the population. As has been rightly observed, “...prisons can be breeding grounds for infection. Overcrowding, lengthy confinement within closed, poorly lit, badly heated and consequently poorly ventilated and often humid spaces are all conditions frequently associated with imprisonment and which contribute to the spread of disease and ill-health. Where these factors are combined with poor hygiene, inadequate nutrition and limited access to adequate health care, prisons can represent a major public health challenge.”

Prisoners cannot fend for themselves in their situation of detention, and it is the responsibility of the State to provide for health services and a healthy environment. The State must as much as possible ensure that healthcare provision in prisons is of the same quality as that of the outside population. In fact, in some cases the need for health care and treatment will often be greater in a prison than in an outside community. This is because prisoners may enter prison when they are already in a bad state of health and the unfavourable conditions in prison may exacerbate their situation. Prisoners may also be subjected to violence either by their fellow inmates or by prison officers, and with restricted means of communication with the outside community, one’s health status may deteriorate if access to adequate healthcare is not facilitated by the State.

In Kenya, where the overall health system is chronically insufficient, prisoners’ access to even basic health care provisions pose a challenge. It is thus against this backdrop and in furtherance of the Commission’s mandate of monitoring places of detention that the this monitoring exercise was conducted with the aim of assessing the level of prisoners’ access to the highest attainable standard of health as envisaged under Article 43 (1) (a) of the Constitution. This survey was conducted between March and July 2018 and targeted 73 prisons to evaluate the adequacy of the Kenya Prisons Service (KPS) medical services and the effectiveness of its medical service’s quality assurance program.

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1.2 Survey Objectives

The objective of the survey was to assess the extent of compliance on the right to health for inmates as provided in the national, regional and international human rights instruments. As such, the objectives of the survey were;

1. To establish the availability and adequacy of health services, facilities and providers in prisons;
2. To establish how KPS handles inmates with special medical needs-including women, psychiatric patients, and inmates with chronic medical conditions and whether they were receiving the care they need; and
3. To assess the overall prison environment and how it contributes towards the promotion and protection of inmates’ health rights.

1.3 Survey Setting

From 2017-2018, Kenya had an average prison population of 51,021 of which 2,585 (5.1%) was female and the male accounted for 48,436 (94.9%). Remand inmates total 19,272 accounting for 37.8% of the entire prison population. The network of 118 prison facilities (some male-only, some con-joined male/female) included maximum (9 prisons) and medium security sites and a host of smaller farm prisons. In a statement by the Commissioner General of Prisons during the International Prisoners Justice Day in 2016, it was noted that the prison population at the time stood at 56,000 in 118 facilities meant for 27,000 inmates, 189% of the occupancy levels.11

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10 Statistics as per data from the 2018 Economic Survey, published by the Kenya National Bureau of Statistics, page 268. It is also important to note that the 82,433 is the cumulative figure for the entire year and not the population at a particular time.

11 https://www.the-star.co.ke/news/2016/07/15/prisons-have-exceeded-inmate-capacity-osugo_c1386323
1.4 Methodology of the Survey

The survey presents findings that highlight the interactions between structural and relational factors influencing Kenyan prisoner health, health risks, and access to health care. To deepen our understanding of the relationship between the social conditions prisoners received, their health care and health, we conducted in-depth interviews of a clustered random sample of prisoners in a purposeful sample of prisons, as well as prison guards and health care workers in the same sites. Our analysis was guided by the concepts of dynamic interaction and emergent behaviour, drawn from the theory of complex adaptive systems. A structured research questionnaire was designed to assist in identifying relevant information.

1.5 Study Population and Sampling

73 prisons, provided for under Appendix 1, were purposively selected based on geographic spread across more than 40 counties, and a range of security levels and gender considerations. Out of the 73 prisons, 23 were female institutions accounting for 31.5% of the total sample population. In each site, the commission had a target of 20 inmates (including 5 known to be HIV positive) and 5–10 prison officers. Participant inclusion criteria included having lived or worked in the selected prison site for 3 months or more and being capable and willing to provide informed verbal consent.

Interviews for the prison officers was purposive (based on rostered staff lists) and designed to ensure a mix of interviews with senior management, non-ranking prison officers and professional health personnel working at the prison clinic or nearby public health centre.
Prisons in Kenya are guided by specific national, regional and international instruments that provide the normative framework for their operations. With regards to the right to health for prisoners, it must be recognized that detention does not derogate the rights and fundamental freedoms all human beings are entitled to. Other than limitations necessary for the condition of detention, no other limitation to the rights of a detainee is permissible. This chapter provides an analysis of the relevant framework in relation to the right to health and which provided a benchmark on the assessment of level of compliance by Kenya Prison Services.

2.1 International Human Rights Instruments

As an affirmation of Kenya’s commitment to regional and international standards, Article 2(5) and (6) of the Constitution of Kenya provides that the general principles of international law shall form part of the laws of Kenya. As such, any treaty or convention that Kenya ratifies shall also form part of the national laws. The Article further cements the place of the General Principles of International law as part of our national legislation. Article 21 (4) imposes on the State the obligation to enact and implement legislation to fulfil its international obligations in respect of human rights and fundamental freedoms.

There are several international, regional and national instruments and conventions that Kenya has ratified and enacted that addresses the human rights obligations of the State as pertains to right to health of persons held in places of detention.
With specific reference to health, the right to conditions “adequate for the health and well-being” of all is recognized in the Universal Declaration of Human Rights (UDHR). The International Convention on Economic, Social and Cultural Rights (ICESCR) recognizes the right of everyone (including prisoners) “to the highest attainable standard of physical and mental health.”

The UN Standard Minimum Rules for the Treatment of Prisoners (UNSMR) also known as The Mandela Rules, although not binding provide for the universally acknowledged minimum standards for the treatment of prisoners and contain specific provisions touching on various aspects of the health rights of prisoners. These standards together with the national laws formed the benchmark for measuring compliance in this survey and the relevant Sections are discussed in detail in Chapter 3.

The United Nations Bangkok Rules on Women Offenders and Prisoners were adopted in appreciation that women in the criminal justice system do have gender-specific characteristics and needs that require deliberate efforts to address. There was also a gap existing in international standards on addressing the needs of women in the criminal justice system until the adoption of the Bangkok Rules. The Rules are crucial to protecting the rights of women offenders and prisoners, explicitly addressing the different needs that women have and the different situations they come from. The Bangkok Rules are also the first international instrument to address the needs of children in prison with their parents.

The United Nations Standard Minimum Rules for Non-custodial Measures (The Tokyo Rules) were developed to provide alternatives to imprisonment with a view to the formulation of basic principles in that area. This closely ties to the campaign on decriminalization and reclassification of petty offences which aims at decongesting places and therefore addressing the various health challenges stemming from congestion within prisons.

12 Article 25, UDHR.
13 Article 12 ICESCR.
14 In December 2010, the Bangkok Rules, were adopted by the UN General Assembly (Resolution A/RES/65/229).
2.2 Regional Framework

At the African level, there are various treaties and protocols ratified by Kenya and subsequent guidelines on upholding the right to health of prisoners. The African Charter on Human and Peoples Rights is the regional overarching instrument on the protection and promotion of human rights. It reiterates the equality of all in the protection of rights under the law. Article 5 of the Charter provides for right to the respect of the dignity inherent in a human being. Article 16 expressly provides for the right to health by stating that every individual, prisoners inclusive, shall have the right to enjoy the best attainable state of physical and mental health and state parties are mandated to take the necessary measures to protect the health of their people and ensure they receive medical attention when they are sick.

With regards to women, the African Protocol on the Rights of Women otherwise known as the Maputo Protocol reiterates the provisions of the African Charter. It provides that every woman shall have the right to dignity inherent in a human being and to the recognition and protection of her human and legal rights.\textsuperscript{15}\textsuperscript{15} In relation to the health rights of women, the protocol mandates states to ensure the rights of women including sexual and reproductive health is respected and promoted by among others, providing for family planning and education and right to be informed of one’s health status including HIV/AIDS and sexually transmitted infections.\textsuperscript{16}\textsuperscript{16} States are further obligated to take all appropriate measures to provide accessible health services and strengthen maternal health care.

Africa also has a regional instrument dedicated to children namely the African Charter on the Welfare of Children. The Charter provides for the equality of all children in the protection of their rights. Every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health.\textsuperscript{17}\textsuperscript{17} Every child accused or found guilty of having infringed penal law shall have the

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\textsuperscript{15} Article 3, Maputo Protocol
\textsuperscript{16} Article 14, Maputo Protocol
\textsuperscript{17} Article 14, ACWC
right to special treatment in a manner consistent with the child’s sense of dignity and worth and which reinforces the child’s respect for human rights and fundamental freedoms of others.\textsuperscript{18}

The African states adopted Guidelines on the Conditions of Arrest, Police Custody and Pre-trial Detention otherwise known as the Luanda Guidelines that aim at assisting states respect and promote the rights of detainees. With specificity to the right to health of inmates, the Guidelines provide that institutions should have in place measures, including health assessment screenings, to reduce suicide and self-harm, such as alternatives to custody, diversion to mental healthcare, promotion of family support, drug treatment and detoxification, and training of officials to identify and address persons who are at risk of suicide and self-harm.\textsuperscript{19}

The Guidelines provide specific provisions for women and provide that all women detainees be provided with the facilities and materials required to meet their specific hygiene needs and to be offered gender-specific health screening and care which accords with the rights to dignity and privacy, and the right to be seen by a female medical practitioner. Women detainees are to further have access to obstetric and paediatric care before, during and after birth, which should take place at hospitals or other appropriate facilities, and never be subject to physical restraints before, during and after childbirth.\textsuperscript{20}

\section*{2.3 National Framework}

\textbf{2.3.1 The Constitution of Kenya}

The Human Rights of prisoners are protected by the Constitution of Kenya, 2010 which is the Supreme Law of the Republic of Kenya. The national values and principles as encapsulated in Article 10 obligates respect to human dignity, equity, social justice, inclusiveness, human rights, non-discrimination and protection of the marginalized.

The Constitution under Article 19 (2) underscores the importance of recognition and protection of human rights and fundamental freedoms as that of preserving the dignity of individuals and to

\begin{itemize}
\item \textsuperscript{18} Article 17, ACWC
\item \textsuperscript{19} Article 25, Luanda Guidelines
\item \textsuperscript{20} Article 32, Luanda Guidelines
\end{itemize}
promote social justice and the realization of the full potential of all human beings. The rights provided for by the Bill of rights are an entitlement of all by virtue of being human beings and are not granted by the state. Discrimination of any group of persons is strictly prohibited under Article 27 and all persons are considered equal before the law and have equal protection of the law. Similarly, Article 28 recognizes the inherent dignity of every person and the right to have that dignity protected.

With relation to prisoners, Article 51(1) of the Constitution makes it clear that a person who is detained, held in custody or imprisoned under the law, retains all the rights and fundamental freedoms in the Bill of Rights, except to the extent that any particular right or fundamental freedom is clearly incompatible with the fact that the person is detained, held in custody or imprisoned. Article 51(3) mandated Parliament to enact a legislation that provides for the humane treatment of persons detained, held in custody or imprisoned and in effect, it saw the enactment of the Persons Deprived of Liberty Act.\(^2^1\)

The Constitution further states that everyone has the right to the highest attainable standard of health, which includes the right to health care services.\(^2^2\)

2.3.2 The Prisons’ Act CAP 90 and the Borstal Institutions Act CAP 92

These two pieces of legislation provide the framework for which prisons and borstal institutions for underage offenders are governed.

The Prisons Act\(^2^3\) under Part VI on Admission, Control and Discharge of Prisoners (Sections 38-41) has elaborate provisions on how the health rights of prisoners should be promoted, protected as well as providing mechanisms for their monitoring. The same is also encapsulated in the Prison Rules under the Act at Parts III on Medical Officers and the Health of Prisoners as well as in Part IV

\(^{2^1}\) Act No. 23 of 2014
\(^{2^2}\) Article 43 (1) (a), Constitution of Kenya.
\(^{2^3}\) Cap 90, Laws of Kenya
on Accommodation and General Management of Prisons together with Part V on Treatment of
Prisoners.

With regards to prisoners under the age of 18, CAP 92 obligates the borstal institutions to provide
an infirmary or proper place for the reception of inmates who are ill. The Act further provides that
there shall be a medical officer stationed in or otherwise responsible for each borstal institution
and who shall be responsible for the health of all inmates of the borstal institution including
conducting medical examinations when required. The Act also provides elaborate provisions with
regards to removal of inmates to hospital including those with unsound mind.

The KNCHR however notes that CAP 90 and 92 are no up to date with the international best
practices and therefore there is need to review them to ensure compliance with the 2010
Constitution, regional and international human rights instruments.

2.3.3 Persons Deprived of Liberty Act CAP

The Act operationalises the aspirations of the Constitution by providing a comprehensive
framework outlining the rights, limitations and responsibilities of persons deprived of their liberty.
The Act reiterates that every person deprived of liberty is entitled to the protection of all
fundamental rights and freedoms subject to such limitations as may be permitted under the
Constitution.

The Act obligates all detention facilities to maintain registers that shall among other details include
the medical history of all inmates.

Section 15 of the Act provides that a person detained, held in custody or imprisoned is, on the
recommendation of a medical officer of health, entitled to medical examination, treatment and
healthcare, including preventive healthcare. Sections 13 and 14 on their part deal with the right
to a nutritional diet and decent beddings and clothing respectively which play a key part in the
realization of the right to health in prisons.
CHAPTER 3: FINDINGS

The KNCHR conducted a total of 973 interviews comprising of 724 male and 249 female inmates and 350 with prison staff (including male and female officers and health workers) in 73 prisons across the country.

In individual interviews, 936 prisoners (96%) and 350 officers (100%) reported feeling anxious about or afraid for their health at some point during their stay or work in prison. With further analysis, five major themes emerged as central determinants of health as well as shaping the access and quality of health services available to prisoners. These themes were:

1. Prison health services;
2. Quality of medical care;
3. Treatment of vulnerable groups in prisons;
4. Sanitary conditions; and

Findings from these five overarching areas of prison life are detailed in sequence in this chapter. The KNCHR is also conscious that different nomenclature is the standard in different countries, in this report we use the term prisoner, inmate and detainee interchangeably.

3.1 Prison Health Services

This theme assesses the level of access to medical facilities and health care in relation to the international, regional and national framework and how that promotes the holistic right to health of inmates.
The UNSMR provides that in every penal institution, there shall be available the services of at least one qualified medical officer who should have some knowledge of psychiatry. The medical service should have close relationship with health administration of the nation and should be able to avail psychiatric services and treatment of mental disability. Sick prisoners who require specialized treatment shall be transferred to specialized institutions. Dentals services must be availed to every prisoner. 24

The Rules further provide that the medical officer shall have the care of the physical and mental health of the prisoners and should daily see all sick prisoners, all who complain of illness, and any prisoner to whom his attention is specially directed. The medical officer shall report to the director whenever he considers that a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or by any condition of imprisonment.25

Other duties bestowed on the medical officer attached to a penal institution include inspecting and advising on the quantity, quality, preparation and service of food, hygiene and cleanliness of an institution, sanitation, heating, lighting and ventilation of the institution, suitability and cleanliness of clothing and bedding and adequacy of physical education and sports. Upon receipt of the above reports and advice from the medical officer, the head of the penal institution must take immediate steps to give effect to those recommendations.26

3.1.1 Availability of a Medical Facility

57 prisons out of the 73 visited accounting for 78.08% had level 2 medical facilities, also referred to as dispensaries. These facilities operate between 8.00 am and 5.00 pm, limiting the timing and nature of medical conditions that they are able to address. This therefore is still a hindrance to access to medical services after the above stated hours considering that prisons are security installations. The security ramifications of allowing inmates access to external medical facilities are discussed further ahead.

24 Rule 22 UNSMR
25 Rule 25 UNSMR
26 Rule 25 UNSMR
The following 7 prisons did not have any medical facility within the institution, accounting for 9.59% of the sample number.

Moyale, Eldama Ravine G.K Prison, Tambach GK Prison and Kabarnet GK Prison do not have a medical facility and relied on public health facilities in close proximity to the prisons. For Kabarnet prison, there is one uniformed HIV Testing and Counselling (HTC) officer. A nurse from the county hospital also does rounds at the prison.

Kajiado men and women prisons also did not have a health facility and they relied on Kajiado level 5 hospital for treatment. However, the Officer in Charge of the prison had secured funds from the county budget allocation and construction of a level 2 dispensary for the prison was underway at the time of the survey.

The situation at Kwale prison was quite alarming. The medical needs of the population of 400 inmates as at the time of the inspection are met by Msambweni Hospital which is about 33 Kilometers away from the prison. This poses a high security risk as well as logistical challenges especially in instances where a number of inmates fall ill at the same time. The prison does not have any trained health personnel.

Despite the general challenges facing the delivery of services amongst most institutions with level 2 medical facilities, some institutions also had challenges unique only to their stations. In Nakuru Main Prison, the physical placement of the dispensary within the prison is not conducive for the smooth and normal running of a medical facility. The dispensary is placed adjacent to the wards where the inmates are held. There were genuine concerns by the medical personnel on the location of the dispensary. Being next to the inmates’ wards puts the personal security of the medical personnel at risk, especially in the event where the prison faces a situation of unrest. Due to its location, the chances of inmates accessing the facility and harming them are higher given the time it would take for the wardens to respond. There is also no privacy in attending to the patients. This is a major concern for the medical personnel, who requested if the same could be
addressed with speed. The facility is also not properly equipped to handle patients. The structure had been improvised so that it can function as a dispensary. The partitions are done with either a curtain or a board. Therefore, everyone at the waiting area is privy to the discussions between the doctor and the patient, which is a breach of medical confidentiality. The consultation room is small with poor ventilation. This poses a risk to the medical personnel, especially when dealing with patients who have communicable diseases that are airborne transmitted. The dispensary also does not have running water. This is a major concern since sanitization before and after interaction with patients is quite important to avoid risk of exposure. The staff proposed that the dispensary should be improved to a level 3 Health Centre in order to be able to provide the required standard of healthcare.

Similar challenges were also experienced in Nyahururu prison. The dispensary had no electricity from February 2016 to March 2017 when the survey was conducted. This was over a year as at the time of the monitoring exercise. The Clinical Officer stated that the OIC had instructed that all departments pay their own bills. This had brought to a standstill almost all the operations of the dispensary. The dispensary had quite a number of fundamental equipment including a centrifuge, sterilizer, microscopes, computers and more. All this equipment depend on availability of electricity. Therefore, the prevailing situation meant that the equipment was not of any help to the dispensary. The clinical officer also stated that it was quite hard for him to do his reports since he had to do them manually.

Some of the best practices with regards to access to Healthcare by inmates was witnessed in Naivasha, Kamiti, Shimo la Tewa and Nyeri Maximum prisons. These prisons have level 3 Health Centres which allows inmates access to medical services around the clock due to availability of wards for overnight watch.

Naivasha G.K prison has a Level 3 Health Centre. The facility is located within the maximum prison, strategically positioned within the facility to ensure security of the medical personnel and also maintain the privacy of the inmates. It has 2 general wards for handling sick inmates who do not have communicable diseases and 8 isolation wards for inmates with communicable diseases.
The wards are self-contained and are also clean and well maintained. Each ward has 10 beds, meaning the facility could comfortably accommodate 20 patients at any one time. The wards also have 2 wheelchairs to assist those who with physical disabilities and those with difficulties in movement as a result of their ailments. The wards have modern adjustable hospital beds which were donated to the institution by the District hospital.

As at the time of the survey exercise, there were 6 inmates in the wards and 4 other inmates who had been tasked with helping the sick ones. They were in charge of preparing their food, cleaning and also movement for those who had difficulties. Cases in point were two inmates, one was an 82-year-old man who was too weak to take care of himself and therefore he had been assigned someone to help him. The second one was an inmate who had become visually impaired during his stay in prison and also needed someone to assist him.

The Health centre has a consultation room where patients are seen and receive preliminary examination before being sent to either the laboratory or the pharmacy, both located within the health centre, for further tests and drug dispensing respectively.

Nyeri G.K prison has a Level 3 Health Centre. Initially, the health unit was a Level 2 dispensary but was later upgraded to a Health Centre after renovations. The facility has 1 general ward and 2 isolation wards which are all clean and well maintained. All the wards are self-contained.

The general ward has a capacity of 16 but can accommodate up to 22 patients. The beds within the wards are not sufficient. However, communication on this issue has already been done to the Ministry of Health. The health centre had not yet started operating on a 24-hour basis. A joint initiative between KPS and MOH was underway to facilitate the same through providing more human resource.

The Health centre has a well-equipped consultation room where consultations and examinations were being conducted. The room is spacious with good ventilation. There is also a pharmacy where the various drugs that have been prescribed by the CO are dispensed, and a well-equipped laboratory in the health centre where rapid and basic tests could be conducted. The United
Nations has also constructed a dental unit with modern equipment and a library for the patients. This is in compliance to the United Nations rule on the requirement of the availability of the services of qualified dentists who offers comprehensive dental healthcare.  

At Shimo la Tewa Main Prison, the prison has an in-house hospital located within the men’s facility and serves both men and the women sections. It has 2 general wards for handling sick inmates and a separate ward for inmates with communicable diseases. The wards are clean and well maintained. Each ward has a bed meaning the facility could comfortably accommodate patients at any one time. The wards also have wheelchairs to assist those who have physical disabilities and those with difficulties in movement as a result of their ailments. The prison institution is also equipped with a health consultation room where patients are seen and receive preliminary examination before being sent either to the laboratory or the pharmacy, both located within the hospital centre in the institution. The inmates are given health talks on a quarterly basis. The prison institution is also equipped with a health consultation room where patients are seen and receive preliminary examination before being sent either to the laboratory or the pharmacy, both located within the hospital centre in the institution.

Other than ensuring the nutritional needs of the inmates are met, the nutritionist assists in monitoring the condition of persons with tuberculosis as well as ensuring that those under medication adhere to the dosage prescribed to them, while the county government ensures the supply of drugs to the facility. People with special needs such as the sick and elderly are provided with a special diet which mostly includes fruits and vegetables, most of which are grown within the confines of the prison.

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27 Rule 22.3 of the SMR.
With regards to the supply of drugs in the prison health facilities, 40 (54.79%) of the prisons visited stated that the drugs were supplied by the Kenya Medical Supplies Authority (KEMSA) while the remaining 33 (45.21%) cited the county governments through the county hospitals as the source of their drugs. Institutions being supplied by KEMSA stated that on some instances there were delays in supplying the drugs due to delayed or accumulated unpaid payments.
3.1.2 Security vis-à-vis access to medical services

An important but unanticipated barrier to health service access came in the form of conflict between the primary mandate of KPS, security, against the right to access health services by inmates. As already stated, the core function of KPS is containment of inmates. This security function of KPS may sometimes interfere with the inmates’ rights to access medical care. For instance, the facility at Nyahururu Prison is located within the greater perimeter of the prison but not inside either of the main or female prisons. Owing to its location, the prison security officers were always in conflict with the prison medical staff. The nurse in charge expressed his frustration when inmates have to be brought from the detention facility to the dispensary. The OIC in the main prison was not quite comfortable with this arrangement, citing security issues that present
themselves with having prisoners outside the prison. He had therefore directed that the medical personnel see patients inside the main prison. There is provision for a small makeshift room where the medical examinations are conducted. The medical personnel have problem with this arrangement stating that the room in the prison is not meant for medical purposes. There is also a proper medical facility within the institution designed and equipped to handle medical issues and therefore no reason for improvisation, causing an inconvenience to the medical personnel. Owing to the above stated situation, the medical facility within this prison was highly underutilized.

Though not as dire as the situation in Nyahururu prison, the feeling was similar in 87.67% of the facilities visited. Most of the officers interviewed stated that they are usually very reluctant to address medical situations that arise during the night. Some stated that after lock down, the standard protocol of unlocking the doors remains even in cases of emergency. This was because of a general fear on who bears responsibility in case something occurs during that period. The officers also stated that sometimes inmates are very conniving and may feign sickness so that they can take advantage of the situation to either break out of prison or harm the officers. These sentiments were echoed by inmates who stated that generally, and especially at night, one would literally have to be dying before they can be allowed access to external medical facilities.

On the contrary, some of the inmates and officers felt that access to medical facilities within places of detention was easier as opposed to outside prison. Some inmates admitted to having been diagnosed with diseases and conditions that they were unable to manage due to financial constraints. They would therefore commit misdemeanours just so as to access medical care. The officers further stated that some of the inmates immediately after admission to the prison request for medical attention. At Nairobi Remand and Allocation prison, the Clinic Officer informed the team from KNCHR that he had experienced an instance where an inmate with kidney problems

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28 It was noted with great concern across a majority of prisons that there was a conflict between the security mandate of KPS and access to health. This problem was mainly experienced when there were emergency cases especially at night after lock down and also where inmates had to be accompanied to external facilities for check-up. The process was quite slow due to the various bureaucratic security arrangements that had to be put in place before inmates could be allowed out of the facility.

29 This was a unique feature in prisons with either level 2 facilities or none at all since they had to refer inmates to external facilities which was considered a high risk security factor.
confided in him that the cost of healthcare outside the prison was so high and unaffordable. He therefore deliberately committed a crime and pleaded guilty so that he could be imprisoned and get the requisite medical attention and also constant meals which he was unable to afford.

The officers also raised concern that the courts were not appreciating the medical facilities within the prisons even for conditions that they were more than capable of handling. Whenever an inmate requested for access to medical care, the courts were quick to give orders to have the inmates taken to the respective government referral hospitals without due regard as to whether the facility in the prison was equipped to handle such a case.

3.2 Quality of Medical Care

Availability of medical facilities does not necessarily transcend to quality medical care. During the survey, several factors were noted as major contributing factors to the standard of care offered by the various medical facilities within prisons.

3.2.1 Medical Examination Upon Entry

According to the UNSMR, a medical doctor is required to attend in a timely manner all prisoners immediately after their admission and undertake all necessary diagnosis and actions with a view particularly to the discovery of physical or mental illness. This is to ensure that all necessary measures are taken for the segregation of prisoners suspected of infectious or contagious conditions, the noting of physical or mental defects which might hamper rehabilitation and the determination of the physical capacity of prisoners for work allocation\(^\text{30}\).

Medical examination upon entry would enable the medical staff to identify and undertake appropriate measures as regards any pre-existing medical conditions, effects of withdrawal of drugs, traces of violence and vulnerability to self-harm.\(^\text{31}\)

\(^\text{30}\) Rule 24, UNSMR

From the findings of the survey, although newly admitted inmates are not given a thorough medical exam at the time of admission, there is preliminary screening for the most common communicable diseases. This is through a screening tool referred to as the PF-10 form. However, the prison authorities felt that such tests should be improved to include blood tests to assist them detect any medical issues in good time and hence make it easier to mitigate the situation. However, it was also raised that such a venture would be quite costly.
Though not anchored in any law but as a matter of practice, women were also subjected to a pregnancy test before admission. This was done to avoid instances where an inmate claims to have fallen pregnant whilst in custody. 32

The importance of such medical examinations at the point of admission cannot be emphasized. During a visit to Lodwar prison, it was observed that an inmate had been admitted to prison with Hepatitis B. This inmate went on to infect 90 other inmates and 5 prison officers with the said disease. This was of major concern to the Commission as hepatitis is considered a very serious disease. More worrying was the fact that this was only detected when the inmates had

32 This was the submission of the Officers in charge of the female facilities visited.
participated in a blood donation exercise and not through internal mechanisms within the system to curb such infections.

3.2.2 Inpatient Treatment

The capacity of prisons to provide inpatient treatment to prisoners is an important factor taking into account the usually restrictive rules governing the transfer of inmates to external medical facilities. Prisons should be able to offer inpatient treatment to prisoners suffering from less serious diseases that do not require the intervention of a qualified specialist or the availability of special equipment. There is a clear disparity amongst the prisons in this regard. While some prisons were sufficiently equipped to handle patients suffering from less serious diseases, other prisons were struggling to meet this minimum requirement.

Prisons with dispensaries were facing a number of challenges which in turn affected the delivery of quality health care for the inmates. Generally, level 2 facilities have no wards or beds for 24-hour observation of patients since they do not operate at night. Inmates in need of intense medical attention are therefore have to be referred to the respective county referral hospitals for further treatment. This has security ramifications as discussed above section 3.1.2.

46 (63.01%) of the prisons visited had ambulances to handle emergencies and referrals that arise within the prison to the respective county hospitals. The remaining 27 prisons (36.99%) relied on the vehicles allocated to the prison or liaised with the county government for transport. This was to avoid the security risk of having inmates in alternative forms of transport other than official government vehicles. An example is Kakamega main prison which has an ambulance to cater for referrals to Kakamega County Hospital for cases that require admission. The ambulance used by the men’s Prison is the same one that serves the Women’s Prison.
3.2.3 **Communicable Diseases**

Interviews with both inmates, prison security and medical staff corroborated the statistics by the Kenya National Bureau of Statistics on overcrowding at 189% in places of detention and the associated negative effects on both inmates’ and officers’ physical and mental health. In Nyahururu prison, inmates described sleeping conditions that included having to sit all night or having to sleep head-to-shoulder on the floor without a mattress. It is worth noting that overcrowding was observed in the men’s prisons and not the women’s.

Mirroring inmates’ concerns, officers from all prisons reported high levels of anxiety relating to overcrowding and, in particular, the risk of airborne infectious disease transmission.

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The main communicable diseases that affect inmates include: hepatitis B, hepatitis C, HIV/AIDS, chicken pox and tuberculosis. The selection is based on the conclusions of various studies, which identify these conditions among the most dangerous and widespread within penitentiary facilities. As noted by the WHO, people in prisons are particularly at risk for hepatitis B, hepatitis C and HIV, due to their own vulnerability compounded by the characteristics of the environment. The prevalence of HIV, hepatitis B and hepatitis C is particularly high in prisons and all modes of transmission of these diseases occurring in the community also occur in prisons: through blood, sexual activity and vertical transmission to a child. The same applies to tuberculosis, which also occurs in prison much more often than among the general population.\(^\text{34}\)

The availability of premises for isolating inmates suffering from or suspected of infectious or contagious conditions is crucial for preventing the transmission of such diseases to other

\(^{34}\) Dr Eamonn J (2016) The Health of Prisoners: A Focus on Infectious Diseases.
prisoners. When examining a prisoner, the medical practitioner is supposed to pay particular attention to isolating prisoners suspected of having infectious or contagious conditions for the period of infection and providing them with proper treatment. Therefore, when necessary for clinical reasons, measures should be undertaken to isolate prisoners for their own benefit and the safety of other persons.35

Save for the facilities which have level 3 medical facilities which are properly equipped with both general and isolation wards, 78.08% of the inspected prisons used segregation cells to isolate inmates with communicable diseases. In the Kenyan Context, segregation cells are meant for punishment, not handling patients. Therefore, they are not sufficiently equipped to handle patients. There is also the psychological effect where a sick person has to make do with a room that is ordinarily known to be for punishment. Even so, the medical personnel observed that the segregation cells were not sufficient and at times some patients had to share one room. The main communicable disease that plagued the prison was drug resistant tuberculosis. Skin diseases are also very common.

35 Rule 30 of Mandela Rules
The veracity of a lack of proper management of inmates with contagious diseases was witnessed in Lodwar prisons where inmates contracted Hepatitis B from one inmate who had not undergone testing before being placed in the cell blocks.\textsuperscript{36} At the same station, it was also noted that 30 inmates had contracted chicken pox but were yet to receive medical attention as at the time of the visit. The OIC had contracted the same from the inmates and was on sick leave during the visit. This further emphasizes the need for proper health facilities within places of detention to curb instances where such diseases are then transmitted to the outside world.

During the inspection visits, it was noted that Eldama Ravine G.K Prison, Tambach G.K Prison, Kitale Women G.K Prison, Kitale Annex G.K Prison, Kapsabet Women G.K Prison, Kapenguria G.K Prison, Kwale Prison, Kabarnet GK prison and Malindi prison, accounting for 12.33% of the prisons visited, did not have any designated areas for isolation of inmates with contagious diseases. Inmates with contagious diseases were kept in the same wards with the rest of the inmates. In Wundanyi

\textsuperscript{36} it is important to note that blood tests are not part of the screening procedures before admission of inmates and therefore it is a situation that cuts across all prisons and not just Lodwar prison.
Women’s prison, prisoners with tuberculosis and those with chicken pox are put together. This is mainly as a result of lack of space to isolate the cases separately.

### 3.2.4 Records and Management of Drugs for Inmates

International standards dictate that the health-care service shall prepare and maintain accurate, up-to-date and confidential individual medical files on all prisoners, and all prisoners should be granted access to their files upon request. A prisoner may appoint a third party to access his or her medical file. Medical files shall be transferred to the health-care service of the receiving institution upon transfer of a prisoner and shall be subject to medical confidentiality.  

As noted earlier, once a prisoner has been admitted to prison, a medical form (PF-10) is filled. This serves as the medical record for the inmate. Every time an inmate has a medical situation, it is recorded on to the PF-10 as part of his medical history. This form is part of the transfer documents where an inmate is to be moved to another facility in order to inform the receiving facility on the medical situation of the inmate.

From the survey findings, there is a comprehensive records management system in place. HIV data was kept separately and privately due to the sensitive nature. Patients were updated regularly on their progress and also given general information on health and how to manage themselves.

The major challenge with records management was where an inmate, prior to being admitted in prison, was undergoing treatment but they are unable to recall the medication that they were on. There are others who are unaware of pre-existing conditions which are not detected at the point of entry and only noticed when the situation has gotten out of hand.

It was noted across all prisons that inmates who get medical prescription drugs are never allowed to keep them in the wards. The drugs are labelled with each inmate’s name and stored in a common drugs chest wherefrom they then get to be dispensed at the appointed time by a designated prisoner under the supervision of an officer.

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37 Rule 26 of the UNSMR
3.2.5 Regular Medical Examinations

Regular (prophylactic) medical examinations are crucial both in terms of prevention and timely diagnostics. Regular medical examinations are available for people outside prison so, based on the equivalence of care principle, a comparable solution should be available for prisoners.\textsuperscript{38}

International legal instruments recommend regular screenings for specific communicable diseases as a preventive measure but do not include any rules concerning general prophylactic examinations.

The scope of general prophylactic examinations, both inside and outside prison, may differ. KPS is having a major challenge in providing this service to inmates due to the high number of inmates as compared to that of the medical personnel. There is also an issue with the availability of funds to conduct such an exercise. This therefore puts the prisons department and the inmates at a great risk of a disease outbreak that may turn into an epidemic due to lack of early detection and mitigation.

Occasionally, some of the prisons organize for medical camps with the support of development partners and other community organization where inmates are given free medical check-ups and treatment.

\textsuperscript{38} Rule 24 of the Mandela Rules state that the provision of health care for prisoners is a State responsibility. Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status.
Photo 7: A TB awareness and screening exercise that was being conducted at Makueni Remand and women prisons as at the time of the inspection courtesy of the Health Department of Makueni County.
3.3 Treatment of Vulnerable Groups in Prisons

The Constitution in its aspirations, national values and bill of rights calls for reasonable accommodation for certain vulnerable groups. Similarly, the survey identified the following categories as vulnerable in prisons and aimed to assess their treatment in prison as pertains to their right to health:

- HIV positive prisoners;
- Prisoners with mental disability;
- Prisoners with physical disability;
- Women; and
- Children accompanying mothers.

The following section analyses a sample of these groups’ treatment in prison in relation to their right to health and unique vulnerabilities.

3.3.1 Management of Inmates with HIV

National Guidelines for HIV Testing and Counselling in Kenya recognizes prisons amongst the additional populations that may also be vulnerable to HIV infection. The guidelines emphasize that concerted effort be made to ensure that these populations have equitable access to HIV testing and counselling. For ease of access by different populations, Provider Initiated Testing and Counselling (PITC) approach encompasses different strategies delivered in two main settings i.e. community-based (stand-alone HTC centres, outreach services, and home-based testing and counselling (HBTC)) and facility-based (static sites integrated within hospitals and clinics). Prisons have embraced the facility based approach which has seen training and deployment of HTC counsellors in prisons across the country.

With regards to patients with HIV, the survey’s findings are that inmates are placed on double ration of the diet fed to the general prison population with special diet only upon prescription from a medici. They inmates are also able to get dietary supplements from the county’s Comprehensive Care Centre (CCC). There is also adequate supply of antiretroviral drugs for the
patients. They are also encouraged to join a support group where they receive counselling from the chaplaincy and uniformed HTC officers, welfare officers of the institution who are trained in counselling with the support from the HTC officer.

As good practice, HIV positive inmates should not be isolated from the rest of the inmates. Respect for this principle was noted uniformly across all prisons visited and is lauded. In Nairobi Remand and Allocation prison, the inmates had their own cell blocks. This was however not to add on to the stigma that such patients face but to ensure their proper management.\(^{39}\)

Management of inmates living with HIV/AIDS was one of the most commendable aspects of the access to health by inmates within prisons as there was a 100% positive feedback from the inmates, the prison management and the medical staff within the prisons.

### 3.3.2 Access to Reproductive Health Care for Female Inmates

According to the UNSMR, there shall be special accommodation for all necessary pre-natal and post-natal care and treatment in all women’s penal institutions. Arrangements shall be made wherever practicable for children to be born in a hospital outside the institution. If a child is born in prison, this fact shall not be mentioned in the birth certificate. Where nursing infants are allowed to remain in the institution with their mothers, provision shall be made for a nursery staffed by qualified persons, where the infants shall be placed when they are not in the care of their mothers.\(^{40}\)

With the development of crime over the years, there has been an increase in the number of women and adolescent females that are incarcerated each year, and they represent an increasing proportion of inmates within Kenya’s correctional system. Most of these women and adolescent females often come from disadvantaged environments and have high rates of chronic illness, substance abuse, and undetected health problems. Most of these women are of reproductive age

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\(^{39}\) Interviews with both the medical staff, the inmates and the warders confirmed that since this is a category of inmates that are in constant need of special attention, managing them on their own is easier as opposed to having them in the general block especially in case of a medical emergency during the night.

\(^{40}\) Rule 23 of the UNSMR
and are at high risk of unintended pregnancy and sexually transmitted infections, including human immunodeficiency virus (HIV).

Understanding the needs of incarcerated women and adolescent females can help improve the provision of health care in the correctional system. During the admission process into a female prison facility, the prison management subjects the inmates to a pregnancy test and although screening of STIs is optional. This seemed to be the practice amongst all the female facilities that the team visited while conducting this survey. The physical examinations are done to detect any pre-existing health problems that might exist, so that they may be addressed early enough. Those who are reluctant to undergo the screening are taken through a counselling process where they are enlightened on the benefits of undergoing such screenings.

Once an inmate has been identified to be pregnant, they are immediately put on an anti-natal care program till the time that they are due. The expectant inmates are also put on special diet which include fortified foods in order to provide the necessary nutritional supplements that they require. They are then transported to the nearest health facility for delivery. Institutions such as Langata women prison and Shimo La Tewa Women’s prisons have a maternity wing within the prison available for expectant mothers. The women are provided with information regarding their expectancy to ensure that the expectant mothers are well prepared for the childbirth. Inmates who may require specialized services such as a pap test are referred to the nearest government facility.

Mothers are allowed to have their children with them in prison until the child attains the age of 4 years. During this period, the prison takes care of the children. They are provided with a special diet in appreciation of their nutritional needs. They also have a day care centre where the babies are left as the mothers attend to their daily duties. Unlike the male prisons, most of the female

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41 Though no legal basis has been established for this, there seemed to be consensus amongst the administration of the female institutions that pregnancy screening was mandatory to prevent instances where an inmate claims to have fallen pregnant while in custody.

42 This is in line with Rule 23 of the Mandela rules which provides that in women’s prisons, there shall be special accommodation for all necessary prenatal and postnatal care and treatment. Arrangements shall be made wherever practicable for children to be born in a hospital outside the prison. If a child is born in prison, this fact shall not be mentioned in the birth certificate.
facilities were highly underutilized. This provided an opportunity to the prison management to have a specific ward for mothers who had their children with them.

The women are also provided with sanitary towels and introduced to family planning methods, especially those who are almost due for release. This was deemed necessary since most of the women were engaged in crime to fend for their children or some had been incarcerated for abandoning their children. It was therefore important to not only teach but also avail family planning methods for those who were interested. Though it was noted with concern that such programs are not sustainable since they heavily relied on support from development partners as opposed to the government.

During the Commission’s visit to Kakamega women prison, there was a team from an NGO Marie Stopes Kenya which had come to offer a talk on free family planning services to the inmates. However, the Commission noted the challenge of inadequate supply of sanitary towels, toilet papers and soap by the government. Consequently, the facilities rely on donors in most instances.

However, some institutions did not provide for services to specially cater for the reproductive health of the prisoners. In Wundanyi women’s prison, the facility is not equipped to handle expectant mothers and such inmates have to be referred to a nearby hospital for purposes of delivery and post-natal care. This is greatly compounded by the fact that the facility is unable to deal with emergencies due to lack of a resident doctor and an ambulance to transport urgent cases. Children born to these inmates are subsequently separated from their mothers. The prison also lacks beds for nursing mothers and their children. In addition to this, such children are denied their right to education as they do not go to school once they become of age.
In Malindi Women’s prison, there is no budget available to cater for the new-borns and as such, the female officers had to make contributions from their private accounts to meet these expenses. The institution facility does not provide services for expectant mothers. The latter would have to access antenatal, child birth and postnatal care from Malindi sub-county hospital.

In Kwale women’s prison, it was observed that the inmates lack under garments which is especially problematic during their monthly menses. The prison also does not have any facilities to cater for reproductive health of the inmates hence those in need are Msambweni Hospital.
3.3.3 Inmates With Disabilities

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.\(^{43}\)

Prisoners with disabilities are a vulnerable group within the prison population and special measures and reasonable accommodation must be accorded to protect their rights. The difficulties people with disabilities face in society are magnified in prisons, given the nature of the closed and restricted environment and violence resulting from overcrowding, lack of proper prisoner differentiation and supervision, among others.\(^{44}\) Prison overcrowding accelerates the disabling process, with the neglect, psychological stress and lack of adequate medical care. In order to ensure the equal treatment of prisoners with disabilities and the protection of their human rights, prison authorities need to develop policies and strategies which address the needs of this vulnerable group in prisons. Such policies should be informed by the United Nations Convention on the Rights of Persons with Disabilities and national legislation, and address issues such as staff training, classification, accommodation, health care, access to programmes and services, safety, preparation for release, early conditional release and compassionate release, as a priority.

The UNSMR provides that insane prisoners shall not be detained in prisons but shall instead be placed in a mental institution. All other prisoners suffering from other mental diseases shall be observed and treated in specialized institutions under the supervision of a medical doctor.

In Kenya, the data on persons with disability in places of detention is not easily available. This is because there is no deliberate effort by KPS to collect data on persons with disability. Considering their special needs, this oversight therefore means that the prisons are inadequately equipped, in both manpower and finances needed to provide the necessary reasonable accommodation to

\(^{43}\) Convention on the Rights of Persons with Disabilities, Article 1  
\(^{44}\) Handbook on Prisoners with Special Needs, United Nations Office on Drugs and Crime
mainstream the stay of PWDs in prison. This oversight also manifests itself in the national statistics on PWDS in prisons.\textsuperscript{45} KNCHR recorded 197 PWDs during the survey.\textsuperscript{46}

From the survey, only 21 (28.77\%) prisons from the total sample population were recorded to be disability friendly. The parameter of measure for disability friendly facilities included prisons with ramps, modifications on sanitary facilities for easy access by PWDS and prisons without storied buildings. This was mostly in female institutions which were relatively small due to the number of inmates. The remaining 52 (71.23\%) prisons were structured in ways that made it very hard for PWDs to operate without any form of assistance.

\begin{figure}[h]
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\includegraphics[width=\textwidth]{chart.png}
\caption{Graph indicating the trends of facilities in terms of being disability friendly}
\end{figure}

Due to their vulnerable physical condition, prisoners with disabilities are easy targets for abuse and violence from other prisoners and prison staff. Interviews with PWDs across the prisons visited clearly showed their vulnerability. Going back to the argument on security vs right to health of

\textsuperscript{45} in the annual Economic Survey of 2018 published by KNBS on the demographics of prisoners, the only public statistical overview of Kenyan prison population, persons with disabilities are not mentioned at all.

\textsuperscript{46} There were 168 inmates with mental disabilities and 29 inmates with physical disabilities. It was also noted that knowledge of the officers on PWDS was very limited and capacity building on the same was needed. Most did not consider persons with mental disability as PWDs.
inmates, most inmates with disabilities complained that they are not allowed some assistive devices which are considered as weapons in prison. The same sentiments were echoed by the prison officers who also stated that it’s a tough call and the disparity in the management of PWDs across the various prisons was because it was left to the discretion of the officer in charge to guide how PWDs are to be managed. 32 (43.84%) prisons from the total prison population were recorded to have accommodations to facilitate the stay of PWDs in prison despite not being disability friendly. This included provision of assistive devices, having PWDs in wards which were comfortable enough to facilitate their daily operations, improvisations to ensure they could use bathroom facilities without help and engaging them in programs that they felt comfortable enough to participate in.

At the time of the survey, inmates with mental disability across all the facilities visited were not receiving regular individual and group therapy that could improve their mental condition. This situation was occurring because neither facility had psychiatrists to perform this work. In fact, there was a major concern from all the prisons where this survey was conducted that prisons did not have the capability of handling inmates who had mental disabilities.

The lack of appropriate medical personnel to handle such a vulnerable category of inmates places these inmates at risk of receiving poor or untimely psychiatric assessments and inadequate monitoring of their mental conditions. None of the prisons visited had a psychiatrist to handle issues of mental health. It was also noted that there were no special wards for this special category of inmates. They were kept in the general wards with the rest of the inmates. This poses a threat to both them and the other inmates. The KNCHR survey team was also informed that these patients are constantly kept under medication to manage their condition. They are not engaged in any reform activities in the prisons because of their unstable nature. This goes against the core mandate of prison which is to rehabilitate.

In Malindi Prison, a psychiatrist from Port Reitz mental hospital visits the facility every three months to examine and give prescriptions. Such inmates are however not detained separately. The welfare officer is a trained counsellor thereby providing appropriate psychosocial support to the inmates.
Kakamega Women’s Prison is not fully adapted for easy use by persons with disabilities. The buildings and the prison compound can present challenges to persons with mobility problems. Further, inmates with mental disabilities are unlikely to receive appropriate care. This is because the prison does not have trained providers of psychiatric care for inmates with mental health problems. However, the Prison makes arrangements for sick prisoners to be attended to at Kakamega County Referral Hospital. Where the condition cannot be managed at the County Hospital, inmates are referred to Mathare Mental Hospital in Nairobi. During the inspection the Commission’s team noted two inmates held in separate cells for convicts who were on treatment for mental illness.

Persons living with disabilities in Malindi Prison are allowed assistive devices while in custody while the 3 epileptic persons (in the male section) as at the time of the inspection are always required to be with someone and are on medication to mitigate their condition. Although the Hindi Prison had no persons living with disabilities as at the time of the survey, their presence in the facility would be greatly disadvantaged as the institution is not sensitive to their needs; it is yet to set up ramps and easy walk ways meaning that they have to be carried around by their fellow inmates or use assistive devices in their movement around the facility.

### 3.3.4 Rehabilitation of Drug Addicts

International classification of diseases defines dependency syndrome as: “A cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had a greater value”.47

In line with the Constitutional provisions on the right to the highest attainable level of health care to all, persons with substance use disorders are entitled to access quality healthcare services. One of the operationalization of this provision has been through the establishment of the National Authority for the Campaign against Alcohol and Drug Abuse (NACADA) that coordinates a multi-sectoral effort aimed at preventing, controlling and mitigating alcohol and drug abuse in Kenya.

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NACADA recognizes the following key players in supply suppression include Parliament, County Governments, National Police Service, Anti-Narcotics Unit, Ministry of Health (Pharmacy & Poisons Board and Government Chemist Dept.), Customs and Immigration Services, Kenya Bureau of Standards, County Alcoholic Drinks Control Boards, the Judiciary and criminal justice system, as well as Prisons and Probation Services.

Further to the establishment of NACADA, there is also a mental health policy\(^\text{48}\). The aspirations of Kenya’s Mental Health Policy 2015-2030 priority actions which include: developing a National strategic program on substance use management; investment aims to improve access to effective substance use management; capacity building and quality assurance to meet the guidelines and standards for evidence-based best practices in substance use management; integrating substance use management in the health care and social welfare system in the comprehensive continuum of care.

Kenya has developed a protocol\(^\text{49}\) available to all service providers countrywide for use in provision of standardized and quality healthcare services to alcohol and drug users and to enable appropriate management of substance use and its related health and social consequences. It is based on international best practice to manage substance use disorders and is a useful and practical guide for practitioners dealing with substance abuse problems in Kenya. It provides a humane and scientific approach delivered by skilled practitioners in order to assist the alcohol or drug dependent person to attain the highest level of personal, professional, familial and social functioning.

Despite all these structures, the rehabilitative programs are not reflected within Kenya’s penal system.

It was noted with great concern from the medical staff within the prisons that there are no programs designed to rehabilitate drug addicts within most places of detention. Such inmates undergo such a horrid time while incarcerated due to the withdrawal symptoms. At Wundanyi

\(^{48}\) Kenya Mental Health Policy: Towards Attaining the Highest Standard of Mental Health, Ministry of Health.

\(^{49}\) The National Protocol For Treatment Of Substance Use Disorders In Kenya 2017, Ministry of Health
prison, there were four alcoholics who were exhibiting withdrawal symptoms and had not received any treatment.

On the other hand, Malindi Prison and Shimo la Tewa had quite innovative ways of rehabilitating such inmates. At Malindi prison, former drug users are enrolled in methadone therapy to help with dealing with the effects of withdrawal while at Shimo la Tewa Prison inmates with a history of drug abuse are put under support groups to promote their recovery. Organizations that deal with drug and substance abuse such as Reach Out Centre and Muslim Education and Welfare Association (MEWA) partner with the prison to ensure the inmates are rehabilitated.

3.4 Sanitary Conditions

Sanitary inspections have a specific role in terms of prevention and timely addressing of hygiene-related problems. The regular performance of such inspections is an indication for the overall level of sanitary control in prisons. The United Nations require the performance of regular inspections of the conditions of detention including: quantity, quality, preparation and service of the food and water, hygiene and cleanliness of the prison and the prisoners, sanitation, heating, lighting and ventilation of the prison, suitability and cleanliness of the prisoners’ clothing and beddings.50

Each of the prison monitored either had an in-house public health officer51 or one that had been seconded to the prison by the county government. The local public health departments under the County Governments are also involved in conducting public health inspections. During the survey, a public health officer from Nakuru County accompanied the officers from KNCHR during the inspection while Kitale medium and Eldama Ravine prisons had also been audited by the county government public health office. From the inspections and also interviews of the Public Health Officers, the general standards of cleanliness and hygiene across the various prisons has greatly improved. This was greatly attributed to the proper management of the institutions by the in-charges who ensured that the inmates kept the institution clean at all times. Availability of water both from the county government and boreholes is also a major boost in keeping the institutions

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50 Rule 15 and 17 of the Mandela rules
51 Rule 35 as read together with Rule 33 of the Mandela rules which provides for a Public Health officer who is to inspect the prison and advise the officer in charge accordingly.
clean. This was evidenced by the reduction of cases of diarrhoea and cholera as per the medical officers.

Despite the overall sanitation improvement in prisons, 90% of the prisons inspected cited that the inmates are not provided with disinfectants and protective gears such as gloves and gumboots due to lack of funds and this exposes the inmates to diseases and high chances of outbreak of diseases such as cholera.

In Wundayi women’s prison, despite having sanitary facilities such as toilets and bathrooms that are readily available to inmates, the prison falls short in terms of hygiene standards as the facility not only lacks disinfectants, sanitary towels, toilet papers and soaps but also lacks protective gear for cleaning such as gloves and gumboots. Lack of proper sanitation has led to the spread of skin diseases which more often than not go untreated due to lack of appropriate medication.
In Shimo La Tewa Borstal, the Commission observed the facility not only lacks disinfectants, soaps and toilet papers but the inmates also lack protective gear for cleaning such as gloves and gumboots. The facility is not congested but nevertheless, the sanitary facilities such as the urinals and the bathrooms located outside are in poor structural and hygienic conditions and this can contribute to the spread of diseases.

In Kericho main prison, the Commission team found the facility to be dirty. Although there were toilets and bathrooms in all the wards, the same are not cleaned regularly and this makes the environment in the wards very nauseating and unhealthy. It was unclear why the prison officers were unable to ensure that the inmate clean their dwelling places.

The inspection team noted the following prisons that really stood out in in upholding high standards of cleanliness for their institutions; Kibos main and medium Prison, Shikusa borstal, Langata women, Shimo la tewa women, Nakuru Women, Nyeri Main, Nyeri medium and Nyeri women, Kamae Borstal, Kamiti YCTC, Embu women, Naivasha main, Naivasha women, Lodwar women and Kericho women.
In Kibos medium prison, toilets and bathrooms are in all the wards and cells and they are cleaned on a daily basis. There is also adequate supply of water at the Prison and high standards of hygiene are generally maintained. Prison officers inspect the wards and cells daily to ensure that they are constantly clean. Further, the Public Health Department also conducts inspections of the Prison on a quarterly basis.

This was also observed in Kibos main prison where the Commission’s team established that the facility had toilets and bathrooms in all the cells and wards and they were accessible to all the inmates. The facilities were also clean and in good condition. There is adequate supply of water at the Prison and therefore cleaning is done on a daily basis, sometimes twice a day (especially during the rainy season). In case of any water shortage, Kibos Sugar Factory supplies the Prison with water. Inmates who clean toilets are provided with protective gear. The facility also supplies inmates with disinfectants. On a quarterly basis, an officer from the Department of Public Health inspects the prison to assess its standards of hygiene.

At Shikusa Borstal Institution, the inspection team observed that a high standard of hygiene has been maintained at the Borstal institution. There’s more than enough water and therefore wards are cleaned on a daily basis. The kitchen is also cleaned twice a day. Further, a public health officer
from the County Public Health Department periodically visits the facility to conduct sanitary inspections and to advise on what improvements need to be made, if any.

Kericho women’s prison has strived to ensure mothers with children are held in clean quarters and given sufficient bedding for the children. Sanitary facilities are available and located within the wards. The facilities are shared by all the inmates in each ward. However, disinfectants are inadequate and sometimes the facility uses ashes as an alternative for disinfectants. Similarly, tissue papers and soap for inmates are inadequate. The prison officers conduct regular inspections of the wards and cells to ensure that the highest possible standards of hygiene are maintained.

Congestion remains a major challenge especially in the cell blocks which remain very stuffy due to the high population which affects air circulation and poses a great health risk especially for inmates with respiratory diseases like asthma, bronchitis among others. In Lodwar prison, the Commission was informed of instances where inmates would pass out due to lack of air. This was quite alarming given the security and health risks that may arise especially if such cases were experienced during the night.

3.4.1 Waste Disposal

The government has come up with a number of measures on how medical waste should be handled in order to reduce the risk of infection among those working in the sector. Chief among the raft of measures is the regulation of the disposal of hazardous waste. Through the National Guidelines for Safe Management of Health Care Waste, it lays down the procedures for handling the entire cycle, including waste collection, storage, transportation and disposal.

Every health facility that the KNCHR visited had the conspicuous red, yellow, and black waste bins. These are meant to separate the various medical waste based on how hazardous they are. Once separated, the prison medical personnel with the help of the public health officer dispose the non-hazardous waste. The hazardous wastes are taken to the District hospitals which have incinerators.
3.5 Food and Nutrition

According to international standards, every prisoner is to be provided by the prison administration at the allocated hours with food of nutritional value adequate for health and strength, of wholesome quality and well prepared and served. Drinking water is also to be available to every
prisoner whenever he or she needs it. Of the inmates interviewed, 93% stated that the quantity and quality of food served in prisons was insufficient. The remaining 7% who answered in the affirmative were mostly HIV positive inmates who are given double portions.

Along with overcrowding, nutrition was the most heavily emphasized health concern among inmates though the officers and prison administration held a different opinion.

For the HIV positive patients, lactating mothers and the geriatric inmates (in some prisons like Naivasha Maximum and Nyeri Maximum), there were special considerations for these inmates both from well-wishers and the prison management. They were able to have double rations, milk, fruits, fortified porridge and other supplements to enable them cope with their respective situations.

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52 Rule 22 of Mandela rules
Photo 13: KNCHR Commissioner Shatikha Chivusia inspecting the quality of food served to inmates during the inspection.

Photo 14: KNCHR Officer Alice Mbuvi inspecting the food at Wundanyi Main Prison.

Photo 15: A sample of the food at Wundanyi men’s Prison.
CHAPTER 4 : CONCLUSION AND RECOMMENDATIONS

The aim of the inspection was to ascertain the level of prisoners’ access to the highest attainable standard of health as envisaged in Article 43 (1) (a) of the Constitution so as to adequately advise the relevant duty bearers. During the exercise, the Commission was mainly concerned with access to the right to health as well as other accessories that aid in the attainment of this right. The team noted that there was general improvement by KPS towards the process of enhancing the rights of inmates. There was good cooperation from prison management toward the exercise. Officers at various stations were cognizant of the fact that the country is signatory to a raft of laws on reforming prisons and turning them into institutions where human rights promotion and protection takes place. The Commission therefore notes the improvement on various aspects in detention facilities in the protection and promotion of human rights.

The above notwithstanding, a shortage of qualified health workers in prisons, especially medical officers, lack of basic drugs and medical commodities, with the exception of anti-tuberculosis treatment and antiretroviral therapy undermine the provision of even a basic package of primary health services was noted. Pointing to the potentially skewing effect of disease-specific investment in HIV and TB services in prison, our data also demonstrated that prisoners ‘without’ TB and HIV but requiring health care experienced a greater degree of difficulty in accessing responsive services compared with those diagnosed with TB or HIV.

Presenting new evidence in relation to a critical component of the prison health system, our interviews with a range of prison officers produced some critical insights. Officers interviewed in this survey consistently expressed concerns about not only the inmate health but also that of their own. At the very least exhibiting an awareness of international standards, a number of officers expressed concern about prisoners’ right to basic necessities. Perhaps more significantly, all the interviewed officers expressed concerns about inmate (ill)-health because of the potential threat
that this represented to their own and their families’ wellbeing. Acknowledging the inadequacy of health services in prison and their own response to it, a number of officers expressed a desire to be better educated on how to recognize and handle health problems.

4.1 Conclusion

As seen from the findings above, 89.04% of the prison sample had access to a health facility. While this is encouraging, there is need to ensure that the available health facilities are better equipped and better staffed to ensure that they are able to meet the needs of those they serve. In terms of ensuring access to health services, prisoners are arguably amongst the most vulnerable populations in the society. It is therefore crucial that health facilities within prisons should have the capacity to fully meet the medical needs of prisoners. Offering basic and rudimentary services as is the case with all the health facilities within the prisons visited does not help much in protecting prison populations, and by extension, communities. As has been rightly observed by the World Health Organization, “Good prison health creates considerable benefits. It prevents the spread of diseases and promotes health through awareness of what everyone can do to help maintain their own health and well-being and that of others. In addition, however, it can help to improve the health status of communities, thus contributing to health for all.”

Another glaring issue that came out during the inspections is the fact that prisons are by far inappropriate for persons with mental health problems, irrespective of the offences they may have committed. Prisons, as currently structured, have no capacity to address the mental health needs of mentally ill prisoners and therefore holding them is an affront to their dignity and an infringement on their right to health.

Most of the prisons visited are bedevilled by the challenge of overcrowding and congestion which effects the provision of health rights to prisoners, their accommodation, provision of food, cloth and beddings and recreational amenities. Owing to the challenge of congestion and overcrowding

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in prisons the prevalence of skin diseases, respiratory diseases and infections among other contagious ailments is very high.

There is a challenge of provision of special diet to inmate patients requiring such attention as in most instances, double ration was provided in place of the special diet.

Whenever inmates are given drug prescriptions which are not available at the prison health facilities or at the county referral hospitals and the prison authorities cannot afford them, the prisoners are forced to personally incur the cost of their purchase by reaching out to their relatives. Though it was noted that well-wishers too have on occasion stepped forward to fill in this gap.

In terms of sanitation, though great improvement\(^5^4\) has been noted in 90% of the prisons inspected, the issue of protective gear and disinfectants due to insufficient funds was lacking which puts the prisoners at risk of disease that could otherwise have been prevented.

### 4.2 Challenges

The Commission notes the following challenges faced by the various prisons inspected in the provision of the right to health to inmates;

(i) Lack of sufficient health infrastructure, lab equipment, poor health facilities within the prisons,

(ii) Lack of adequate medical personnel including resident medical doctors and regular services by a dentist and a psychiatrist,

(iii) Most prisons do not cater for the needs of persons with disabilities and there is lack of assistive equipment’s for the physically disabled inmates. Most prison facilities /wards have no ramps to ease accessibility for vulnerable groups such as persons with disability,

(iv) In cases where a prison does not have a medical facility or where the medical facility is unable to handle certain diseases, inmates are referred to the respective county medical facilities. Due to the fact that the prison does not have its own health institution, whenever

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\(^5^4\) A status report on Human Rights in prisons (2010-2014) by KNCHR noted the deplorable state of sanitation within places of detention in Kenya
it is unable to foot the piled up medical bills, there is always the threat from the county hospitals for suspension of services which may have dire effect on the health rights on inmates,

(v) Lack of proper and adequate isolation cells to contain inmates with contagious disease such TB & chicken pox,

(vi) Lack of proper methods of waste disposal; and

(vii) Most of the HTC providers are uniformed officers; this is a challenge because they intimidate inmates and thus they may not be open to them.

4.3 Recommendations / Action Points

Based on the survey findings, and by virtue of its constitutional and statutory advisory mandate, the Commission makes the following points for action:

To the Cabinet Secretary, Ministry of Interior and Coordination of National Government and the Commissioner General of Prisons:

(i) Ensure that all prisons are promptly and properly funded so that the basic health, sanitation and nutrition needs of the prisoners are met. Particularly, factor in higher allocations for special diets especially for terminally ill patients those on HIV medication, children accompanying their mothers to prison, pregnant and lactating mothers as well as the elderly prisoners. The budgetary allocation to also cater for the sanitary need of women and provision of protective gear of inmates and officers in the course of their work;

(ii) Establish and maintain partnerships with other state and non-state actors which can offer various forms of support to the correctional facilities, protective gear consumables;

(iii) In conjunction with the Ministry of Health and the County Governments, progressively recruit and deploy more medical personnel including resident doctors and clinical officers to prisons. Proper measures should also be put in place to ensure that the medical practitioners get the required training and the motivation to ensure effective performance of their duties. The uniformed health officers should be exempted from
wearing uniform will on duties in the health facilities so that they don’t intimidate inmates.

(iv) Ensure that at least each prison has a medical facility within the prison for effective services and to save on the transportation cost, time and reduce the security risks of transporting inmates to external facilities. Proper infrastructures must also be put in place, building of health facilities where there is none and well equipping of the small dispensaries and laboratories;

(v) The Prison services to consider revising the current mode of screening inmates and admission to conducting medical examination as a more effective way of preventing and managing ailments health conditions in the prisons;

(vi) Endeavour to have independent water source within the prison compound managed by the Kenya Prison services as a more cost effective and sustainable mode as opposed to the current trend where most of the facilities rely on their respective counties for their water supply.

(vii) There is an urgent need to mainstream the rights of persons with disabilities in prisons and as a starting point embark on development of a policy for the same. More particularly KPS should embark on disaggregating the prisons statistics to adequately capture the various categories of disabilities in the prisons. This data will aid planning and response for their reasonable accommodation including provision of assistive devices, ramps and overall accessibility in the prisons.

(viii) There is need to relook into the welfare and treatment of persons with mental disability and similarly the welfare of the officers taking care of this vulnerable group. From the survey findings, KPS currently does not have the capacity to provide appropriate medical and psychiatric care to inmates. Further, staffing shortages at these medical referral centres are chronic and show no signs of improving. This, in turn, adversely affects quality of health care, which rely on staff support for effective implementation. In addition, physician assistants, who are relied upon to provide a significant amount of primary care to patients, are not as well trained or supervised as they should be. As a result of these problems, patients are and will continue to be at risk of receiving poor care. Finally is
invoking the KPS mandate under CAP 90 for removal of inmates with unsound mind for confinement in mental institutions.

(ix) Embark on measures to protect the well-being and health of inmates and officers in the course of their industry and official duties respectively through the provision of protective gear. There must be a compensation scheme in place for both the inmates and officers who incur injuries including disabilities in the course of their industry and work in prison. The medical insurance for the prison officers must be sufficient to adequately cater for the risks incurred in the course of their duties;

(x) Ensure that the prison service officers are well remunerated this will raise their standards of living and it will also act as a motivation towards performing their tasks effectively.

To officers in charge of prison facilities

(i) Maintain high standards of hygiene within the prisons through proper coordination and control of the operations of the prisons including daily cleaning of the wards, implementing the inspection reports and advising the courts accordingly of the status of congestion in their facilities;

(ii) Prepare a needs assessment and gaps analysis of the medical services its inmate population requires and advice the headquarters accordingly on what medical services it can efficiently and effectively provide in-house;

(iii) Establish and maintain partnerships with other state and non-state actors which can offer various forms of support to the facilities;

To the Judiciary, Office of the Director of Public Prosecutions and the Probation Department

(i) Endeavour to uphold the principle that mentally ill convicts or remandees should not be held in Prisons at all rather, they should be committed to mental health institutions and such issue the requisite orders for the same;

(ii) Issue referral orders for sick inmates to hospitals only when it has ascertained that the relevant prison does not have the required services or capacity to handle the sickness;
(iii) Devise mechanisms of dealing with terminally or seriously ill convicts or remandees. One proposal would be releasing sick prisoners on compassionate grounds. This would enable them to seek alternative care where the prison within which they are hosted is unable to care for them;

(iv) Through the National Council on Administration of Justice conduct periodic monitoring and advice the criminal justice actors on the appropriate measures to address the current state of overcrowding and congestion in prisons including decriminalization of petty offences and embracing non-custodial sentencing for petty offences.

To County Governments;

(i) Compliment the Kenya Prison Services access to quality and affordable health care to the inmates through progressive secondment of medical personnel, facilitating referrals and admission of sick inmates in the county hospitals and conducting medical camps in the prisons;

(ii) Consider allocating more medical supplies and especially drugs to the prison health facilities as these facilities attend not only the prisoners and prison staff but also neighbouring communities around each prison.
### 5.1 Annexure 1: List of Prisons Visited

1. Athi River GK Prison  
2. Busia Main Prison  
3. Busia Women Prison  
4. Eldama Ravine Prison  
5. Embu Main Prison  
6. Embu Women Prison  
7. Hindi Prison Main  
8. Hindi Women Prison  
9. Kabarnet Main Prison  
10. Kajiado Main Prison  
11. Kajiado Women Prison  
12. Kakamega Main Prison  
13. Kakamega Women Prison  
14. Kamae Borstal Institution  
15. Kamiti Maximum Prison  
16. Kamiti Medium Prison  
17. Kamiti Youth Correction and Training Centre (YCTC).  
18. Kangeta Main Prison  
19. Kapenguria Main Prison  
20. Kapenguria Women Prison  
21. Kapsabet Main Prison  
22. Kapsabet Women Prison  
23. Kericho Main Prison  
24. Kericho Medium Prison  
25. Kericho Women Prison  
26. Kibos Main Prison  
27. Kibos Medium Prison  
28. Kisii Main Prison  
29. Kisii Women Prison  
31. Kitale Main Prison  
32. Kitale Medium Prison  
33. Kitale Women Prison  
34. Kitui Main Prison  
35. Kitui Women Prison  
36. Kwale Main Prison  
37. Kwale Women Prison  
38. Langata Women Prison  
39. Lodwar Prison  
40. Machakos Main Prison  
41. Machakos Women Prison  
42. Makueni Main Prison  
43. Makueni Remand And Women Prison  
44. Malindi Main Prison  
45. Malindi Women Prison  
46. Meru Main Prison  
47. Meru Women Prison  
48. Muranga Main Prison  
49. Muranga Women Prison  
50. Mwea GK Prison  
51. Nairobi Remand And Allocation Prison  
52. Naivasha Main Prison  
53. Nakuru Main Prison  
54. Nakuru Women Prison  
55. Nanyuki Prison  
56. Nairobi Medium Prison  
57. Nyahururu Main Prison  
58. Nyahururu Women Prison  
59. Nyandarua Prison
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<td>Nyeri Main Prison</td>
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<td>Shimo Borstal Institution</td>
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<td>Shimo Women Prison</td>
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<td>69.</td>
<td>Siaya Main Prison</td>
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<td>Uruku GK Prison</td>
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<td>73.</td>
<td>Wundanyi Women Prison</td>
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PART 1: GENERAL INFORMATION

NAME OF INSPECTING OFFICER: ........................................................................................................................................................................

DATE(s): ...................................................................................................................................................................................................

NAME OF FACILITY: ..........................................................................................................................................................................

COUNTY: ...................................................................................................................................................................................................

RANK AND NAME OF OIC: ........................................................................................................................................................................

PART 2: CAPACITY OF THE FACILITY

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PART 3: SPECIAL NEED GROUPS

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INSTITUTIONAL STAFF

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Officer In Charge Preliminary Comments:

PRISONER WELFARE ISSUES

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<td></td>
<td>Accessibility and condition of the facilities.</td>
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<td>Are disinfectants, sanitary towels, toilet papers and soap available?</td>
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<td>Availability of protective gear like gloves and boots.</td>
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<td>What are the waste disposal methods available?</td>
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<td>How often are the cells cleaned?</td>
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<td>Are inmates able to shower regularly?</td>
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<td>Availability and accessibility of clean water for general use.</td>
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</tr>
<tr>
<td></td>
<td>How Is Food Prepared (Electricity/ Biogas/ firewood/ Charcoal stoves) and who prepares the food (Special Cooks/inmates /selected inmates.</td>
<td></td>
</tr>
<tr>
<td><strong>Is there a medical register for the cooks on display in the kitchen?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Is Special Diet provided for those who need it? (Diabetics / HIV+, Babies, expectant mothers etc.?)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Water</strong></td>
<td>Availability and accessibility of safe drinking water.</td>
<td></td>
</tr>
</tbody>
</table>

**RIGHT TO HEALTH**

<table>
<thead>
<tr>
<th>Access to medical care</th>
<th>What type of medical facility is available?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Availability of trained personnel.</td>
</tr>
<tr>
<td></td>
<td>Availability and accessibility of drugs.</td>
</tr>
<tr>
<td></td>
<td>Who supplies the medical supplies and after how long?</td>
</tr>
<tr>
<td></td>
<td>Is there appropriate transport to hospitals</td>
</tr>
<tr>
<td></td>
<td>Are there appropriate emergency response measures available?</td>
</tr>
<tr>
<td></td>
<td>Is there a resident doctor in the prison or its vicinity?</td>
</tr>
<tr>
<td></td>
<td>Comments on management of inmates with contagious diseases.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Are inmates given information about the medication given to them?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is periodic medical information and talks on health implications given to the inmates?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inmates with mental complications</th>
<th>Is there specialized treatment for inmates with mental complications?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>sexual and reproductive health rights</th>
<th>Is Adequate pre and post-natal care for expectant mothers available?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Where does childbirth take place?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate of death in prisons</th>
<th>Are there deaths reported in the facilities?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What are the main causes of death? (natural or other- specify)</td>
</tr>
<tr>
<td></td>
<td>What is the process of notifying the next of kin in case of an inmate’s death?</td>
</tr>
</tbody>
</table>

**TREATMENT OF PRISONERS**

<table>
<thead>
<tr>
<th>Vulnerable Groups</th>
<th>Persons With Physical Disabilities.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Are any special measures taken to cater for their needs?</td>
</tr>
<tr>
<td></td>
<td>Are there ramps and easy walkways for PWs?</td>
</tr>
<tr>
<td></td>
<td>Are bathrooms, toilets and other facilities easily accessible to PWs?</td>
</tr>
<tr>
<td>Are inmates using assistive devices allowed their use while in custody?</td>
<td></td>
</tr>
<tr>
<td>Are there policies on reasonable accommodation for those with physical disabilities?</td>
<td></td>
</tr>
<tr>
<td>Are duties allocated commensurate with the disability?</td>
<td></td>
</tr>
<tr>
<td>Persons with mental disabilities - Are they held in separate cells?</td>
<td></td>
</tr>
<tr>
<td>Are they provided with appropriate treatment?</td>
<td></td>
</tr>
<tr>
<td>Are any special measures taken to cater for their needs?</td>
<td></td>
</tr>
<tr>
<td>Is psycho-social care provided?</td>
<td></td>
</tr>
<tr>
<td>Are there considerations to accommodate elderly Prisoners separate from the younger ones?</td>
<td></td>
</tr>
</tbody>
</table>

| Care of inmates with special needs | Are they Provided With Special diets/care, etc.? |
| Are any special measures taken to cater for their needs? |
| HIV positive persons are they separated from the other prisoners? |
| Are they Provided With Special diets/care, etc.? |
| Are any special measures taken to cater for their needs? Supply of ARV’s |
| Children accompanying their mothers / born in prisons. |
| Are They separated From The Other Prisoners? |
| Any special accommodation for the mothers and Children? |