CHAK TIMES
"FOR THE HEALING OF THE NATION"
A PUBLICATION OF THE CHRISTIAN HEALTH ASSOCIATION OF KENYA

HIV and human rights

Contribution of Church health facilities in eliminating stigma and discrimination

In this issue....

ISSUE NO 53: AUGUST - DECEMBER 2017

Contents

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Published by:

Christian Health Association of Kenya

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Human rights abuses still primary hurdle in addressing HIV/AIDS

Human rights are inherent to all human beings, whatever their nationality, place of residence, sex, national or ethnic origin, colour, religion, language, or any other status.

While the United Nations Office on Human Rights observes that we are all equally entitled to our human rights without discrimination, this is not the case for people living with HIV (PLHIV) who are faced with various forms of human rights violations.

HIV related stigma refers to prejudice, negative attitudes and abuse directed at people living with HIV. Discrimination in the context of PLHIV involves treating PLHIV in a different, unjust, unfair or prejudicial way, on the basis of their actual or perceived status.

Simply put, discrimination is 'enacted stigma', and can occur at different levels: individual, family, community or national.

Human rights violations and discrimination against PLHIV occur in the family, community, at the workplace, in schools and in prisons. The family environment creates the context within which most human rights violations occur.

Health and medical centers routinely also fail to recognize the right to privacy of PLWHIV, and neither are staff well oriented to issues of Human Rights.

The combination of ignorance, prejudice and fear creates fertile ground for continued human rights violations and consequently, spread of HIV. On the other hand, openness, acceptance and accessible HIV services are key to its reduction.

Stigma and discrimination against PLHIV have been cited as the primary hurdles in addressing prevention and care issues. They are stumbling blocks to ensuring access to essential services.

In Kenya, the majority of PLHIV fail to report cases of human rights violations because they do not believe that proper action will be taken. There is also poor awareness of the channels of redress when individual's rights are violated.

The major rights that are often denied to PLWHIV have been the right to privacy and confidentiality about their HIV status, right to inherit property, right to found and raise a family and the right to work.

Examples of common forms of HIV-related human rights abuses:

Breach of right to privacy

- Testing a person for HIV without their informed consent.
- Disclosure of a person's HIV status without consent.

Breach of right to the highest attainable standard of healthcare

- Denial of treatment to PLHIV
- Failure to take progressive steps to ensure access to anti-retroviral drugs, treatment for opportunist infections for PLHIV.
- Discrimination by health insurance companies against PLHIV
- Requirement by government or private entities for compulsory HIV tests before provision of essential medical services.

Breach of right to a family life

- Forced sterilisation of women living with HIV.
- Denying HIV-positive people the right to marry solely because of their HIV status.

Breach of right to work

- Refusal of employment due to HIV status.
- Dismissal from employment due to HIV Status.

Breach of right to property

- Disinheritance of widows following the death of their husbands due to AIDS.

Breach of right to integrity of the person

- Verbal, physical or sexual abuse as a response

Very few PLWHIV seek redress for human rights violations through the courts of law. Most of them prefer to seek redress through the church, or alternative forms of dispute resolution such as chiefs and councils of elders.

To address stigma and discrimination against PLWHIV, CHAK has for the last seven years implemented the HIV and human rights project in its network of health facilities. The project began in 2009 and is set to end in December 2017.

This issue of CHAK Times takes stock of the project's achievements in the health facilities in which it has been implemented as well as the lessons learned. This edition of the newsletter also seeks to bring to light some of the human rights abuses most common in Kenya.

NHIF holds consultative meeting with CHAK health facilities

The National Hospital Insurance Fund (NHIF) held a stakeholders' consultation with CHAK health facilities on November 8, 2017, to update them on the proposed move from capitation model to Fixed Fee for Service. The fund's proposal to move to the fee for service model comes in the wake of the challenges experienced in implementing capitation.

Through the move, NHIF hopes to respond to customers' request to access services from any point as opposed to pre-selected health facilities.

According to NHIF, the Fixed Fee For Service model would iron out some of the challenges of capitation in outpatient services.

The NHIF first introduced outpatient services in 2012 for the disciplined forces. In 2015, outpatient services were extended to the beneficiaries of the national scheme.

Challenges in implementation of outpatient capitation have been around access to services, patient outcomes, administration, among other areas.

Under the Fixed Fee For Service model, the benefits package will not change. A total of 662 hospitals have already accepted the offer.

The NHIF had initially put the effective date for the roll out of the fee for service model at November 1, 2017. However, this has had to be pushed forward to the next quarter and only the police will be catered for under the model during the last quarter of 2017.

The hospitals that have accepted the NHIF offer have already signed on their comfortable zones and got letters to confirm this. National and civil servants schemes are yet to adopt the model.

Speaking at the function, NHIF CEO Mr Geoffrey Mwangi informed the hospital representatives that the facilities would be paid using the capitation model during this last quarter of 2017.

However, services to police would be reimbursed under the new scheme as per fixed fee for service signed with each facility.

Mr Mwangi stressed on the need to engage with each facility on the amount of money available to them under the scheme. He added that there was need to keep innovating payment models to address challenges experienced as the national hospital fund continued to grow.

Representatives of CHAK hospitals took the opportunity to engage with the NHIF and raise concerns around utilisation of the fund. Some of the concerns raised are as follows:

- Clients were abusing the Linda Mama package. Although it was meant to assist needy cases to access hospital deliveries, even women who are NHIF members were accessing delivery services through the package. Health facilities were losing revenue due to this abuse.
- CHAK hospitals stressed on the need to improve primary care for chronic diseases like hypertension and diabetes to avoid complications which cost more to treat in the long run.
- It was suggested that NHIF deals with CHAK health facilities as a group. Currently, different levels of health facilities bill differently, even for similar services. Even with the Fixed Fee for Service model, NHIF was negotiating with individual facilities. Separation and division would cause a chronic struggle. It would however take time and effort to get to a point where the CHAK health facilities were able to negotiate as a group.
- It was further suggested that NHIF pay for services according to facility levels for standardization and fair compensation.
- Medical procedures and patient safety, the CHAK members said, were mostly done similarly with the main difference in service between the various hospitals being hospitality. It would therefore important to look at the NHIF rates offered to hospitals in this light.
- The facility representatives asked NHIF to consider paying for services offered not location. Facilities in urban areas would find it easier to access professionals compared to rural and remote areas where it would be difficult to get and pay for a specialist. The NHIF would need to look at things differently to compensate facilities fairly.
- Portability of services was long overdue. The facility representatives also sought to know whether the portability of services would continue in the last quarter of 2017 following the decision to go back to the capitation model.
- The Fixed Fee for Service model had been initially rolled out on November 1. A decision was made

»» Page 5

NHIF meets CHAK health facilties

«« From Page 4

to go back to capitation after only a few days of implementing Fee for Service. Facilities therefore sought to know how the services given under fee for service in this short period would be compensated.

- The refunds given for some pre-authorized procedures were too low, leading to losses for the hospitals.
- The hospitals further sought clarification on how cases that first went through observation before being admitted were to be compensated. This, they noted, had proved tricky especially when a patient first came to the outpatient and had therefore been charged the outpatient fee. In such cases, NHIF recommended that the outpatient fee charged be refunded, yet the patient had already received the outpatient services.
- Uploading of documents to the NHIF online portal has been problematic. Additionally, information about the full range of services offered by NHIF was unavailable on-line. Contact numbers given did not work. The CHAK facilities therefore requested NHIF to enhance its communication by ensuring adequate information was available on-line.
- Some of the hospitals expressed concerns that their daily rebates were too low and sought opportunities to engage and negotiate with NHIF.
- Remote and rural areas such as Lokichoggio did not receive adequate and timely information from NHIF and were a long distance from the nearest NHIF branch in Lodwar. It would therefore be more efficient to send them information via e-mail.
- Health facilities that had already began treating patients under fixed fee for service during the first week of November sought to know how they would be compensated since for the rest of the month, patients would be treated on capitation basis. The hospitals were asked to provide the necessary documentation for the services offered under the fixed fee for service model to the nearest NHIF office.

NHIF CEO Mr Geofrrey Mwangi addresses representatives representatives of CHAK health facilities in the consultative meeting held at the Panafric Hotel., Nairobi.

CHAK General Secretary Dr Samuel Mwenda shares his thoughts with the CHAK hospitals' representatives.

Rights-based approach to health care is enshrined in Kenya's law

BY LENA N.MUYANGA - CHAK

Introduction

The CHAK HIV and human rights project has its basis on the right to health. The right to health was first internationally recognized in the 1946 Constitution of the World Health Organization (WHO), whose preamble defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

The preamble further states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

Key elements of the right to health

It is difficult to pinpoint exactly what the right to health entails, but specific elements that constitute the core content of the right to health have been identified by scholars, activists and relevant UN bodies.

States must guarantee these elements under all circumstances, regardless of their available resources. There is a health baseline below which no individual in any country should find themselves'. Thus, irrespective of their available resources, states should provide the following basic services:

a) Access to maternal and child health care, including family planning
b) Immunization against the major infectious diseases
c) Appropriate treatment of common diseases and injuries
d) Essential drugs
e) Adequate supply of safe water and basic sanitation
f) Freedom from serious environmental health threats

The right to health is frequently associated with access to health care and the building of hospitals. Although this is technically correct the right to health extends further. It includes a wide range of factors that can help us lead a healthy life.

The Committee on Economic, Social and Cultural Rights, the body responsible for monitoring the International Covenant on Economic, Social and Cultural Rights, calls these the "underlying determinants of health". They include:

- Safe drinking water and adequate sanitation
- Safe food
- Adequate nutrition and housing
- Healthy working and environmental conditions
- Health-related education and information
- Gender equality.

The right to health in Kenya

Article 43 of the constitution provides that "every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care". It also provides that "a person shall not be denied emergency medical treatment". The constitution further provides for the protection of the health and safety of consumers (Article 46) acknowledging that the determinants of health are many and may be situated in actions and omissions in other sectors.

• There is a health baseline below which no individual in any country should find themselves

There is therefore need for health and safety standards to be developed to guide all sectors given their interrelations with health.

Kenya boasts of having one of the most progressive constitutions because of its bill of rights. The Bill of Rights, found in chapter four of the Constitution, includes civil and political rights, economic, social and cultural rights and environmental rights. The Bill of Rights is expected to be the framework for social, economic and cultural policies.

Included in the Bill of Rights is a strong equality and non-discrimination provision including the right not to be discriminated on the grounds of one's status of health.

Executive Order No. 2 of 2013[14] sought to distinguish and clearly spell out the functions of the national government. With reference to the health sector, the Order provides that the core mandate of the Ministry of Health (MoH) at the national level shall be; the formulation of the health policy, the regulation of

»» Page 7

Right to health enshrined in law

«« From Page 6

the sector, administration of national referral facilities, capacity building and offering technical assistance to the Counties.

The Fourth Schedule of the Constitution distributes functions between national and county governments and assigns national government with the role of developing health policy.

County governments are charged with functions such as promotion of primary health care, ambulance services, veterinary services, management of cemeteries etc. Read together with the intergovernmental relations Act, County Act and Gazette Notice No. 116 of 9th August 2013, it is instructive on health issues.

Besides the Constitution, key statutes include the Public Health Act, The Pharmacy and Poisons Act, The Medical Practitioners and Dentist Act and The Nurses Act.

The core mandate for the health sector as established by the government is to build a progressive, responsive and sustainable technologically-driven, evidence-based and client-centered health system for accelerated attainment of the highest standard of health to all Kenyans.

For instance, in the Vision 2030 under the Social Pillar, the government commits to improve the quality of life for all citizens through ensuring an equitable, affordable and quality healthcare of the highest standard.

- **Included in the Bill of Rights is a strong equality and non-discrimination provision including the right not to be discriminated on the grounds of one's status of health**

Successes in Kenya in implementing the right to health

The Kenya National Human Rights Commission recognizes the following successes:

Free maternal services

For the first time ever, the government introduced the free maternal care programme in public health facilities in an effort to address the financial barriers preventing poor mothers from accessing skilled birth attendance. The free maternal policy sought to improve the uptake, quality and access - both financial and geographical - to delivery of health care services.

Free Primary Health Care

The year 2012/13 also witnessed the abolition of all user charges/fees on primary health services. This was in relation to the government's endeavor to improve access to health care services and achieve universal healthcare. Reports indicate that the government disbursed Ksh674 million to a total of 2,481 dispensaries for the free primary health care programme.

Budgetary allocation and expenditure

There has been notable increase of budgetary allocations to the health sector

Acquisition of specialized equipment for treatment of terminal illness

In the recent past, the Government has launched the Managed Equipment Services project which shall be implemented in partnership with all the 47 counties.

Challenges in implementing the right to health in Kenya

They include:

- Funding constraints
- Professional malpractices
- Poor administration
- Infrastructural capacity vis-a vis provision of services
- Critical shortage of health workforce
- Difficult transition regarding devolution and resistance to change.
- Lack of capacity among civil society and doctors as watch dogs of governments
- Corruption and leakages of funds existing
- Though there is improved allocation of funds by the government, Health is still not prioritized in the national budget.

Conclusion

The right to health is guaranteed in the Constitution of Kenya. Granted, quite abit of work has been done.

However, there is still a lot to be done and it will take the efforts of both the State and its cooperating partners to ensure that this right is fully realized by all Kenyans.

Strategies to address HIV-related human rights violations

Introduction

The CHAK HIV and human rights project was started in 2007 following a realization that people infected and affected with HIV/AIDS were particularly vulnerable to human rights violations because of their actual or perceived HIV status.

At the time, CHAK had been implementing HIV/AIDS projects for several years and it had become obvious that HIV/AIDS was a significant human rights issue, with compounding social, economic and ethical implications.

Cases of HIV-related stigma and discrimination, disinheritance of property as well as physical and sexual violence against PLWHAs were becoming increasingly common in many communities in Kenya. Such stigma and discrimination had severe repurcussions on PLWHIVs, often leading to non-adherence to drugs.

While recognizing that the provision of timely and effective legal services could have gone a long way to effectively address these issues, CHAK also found that economic disparity, lack of proper information on the law, corruption and poor proximity to the courts had made the formal legal system inaccessible to many of the Kenyans who needed it, especially in the catchment populations of its member facilities.

Many CHAK health facilities serve communities in urban slums, rural and remote areas of Kenya.

It is against this background that CHAK sought funding from the Open Society Institute to address the identified gaps in HIV care in its facilities and improve the quality of life for PLWHIV.

Strategies to address human rights violations through the project

The major activities of the project were identified as follows:

Capacity building

The project aimed to build the capacity of PLWHAs and the health care workers involved in their care and treatment, to create awareness on human rights in their respective support groups, communities and health facilities.

Networking and collaboration

Networking and collaborating with other relevant stakeholders in health and human rights would enrich the project and borrow from experiences of various players.

Economic empowerment for PLWHAs

The project would identify and support income generating activities in the project sites to improve the economic well being of the PLWHIV.

Legal consultancy

This activity was aimed at officially linking the project sites with human rights organizations for purposes of providing legal consultancy services to PLWHAs whose rights had been violated and/or were likely to be violated. This would ensure facilitation of timely and effective legal assistance as and when required. It would also enable CHAK and the legal consultants to identify potential public interest litigation cases.

Project implementation model

The project is founded on a three-pillar implementation model as follows:

- The community pillar serves to build the capacity of community systems and structures to enable the community and PLWHAs to take a pivotal role in responding effectively to resolve human rights abuses and legal of disputes that face PLWHIV.

This pillar is composed of human rights councils comprising four community opinion leaders, two peer educators and a health care worker from the health facility, who is also the overall coordinator of the Council.

- The technical assistance pillar is a panel of local legal professionals willing to work with and for PLWHAs to help them resolve both legal and human rights violations. This pillar works closely and interdependently with the health facility and community pillars as part of an empowered local community mechanism geared towards promoting sustainability of activities beyond the life of the project.
- The health facility pillar supports capacity building of health care givers to understand, identify, and integrate human rights issues into delivery of health care services in order to improve care and treatment outcomes and the overall

»» Page 9

Strategies to address rights abuses

«« From Page 8

quality of life of the client.

Project sites

In June 2007, a needs assessment was conducted in 12 CHAK hospitals to identify suitable sites for implementation of the HIV/AIDS and human rights project.

Following the needs assessment, the following 10 CHAK hospitals were selected for implementation: PCEA Tututumu, ACK Maseno, Maua Methodist, Kima Hospital, AIC Litein, Kendu Adventist, PCEA Chogoria, Friends Lugulu, St. Luke's Kaloleni and PCEA Kikuyu.

These facilities were chosen because each of them had a comprehensive HIV/AIDS treatment and care programme as well as strong psycho-support groups.

In addition, they were located in areas where HIV prevalence and HIV-related human rights violations were very high. Other criteria used to choose the sites were the existence of a strong hospital administration team as well as sound accounting procedures and practices.

In October 2008, following renewed funding by the Open Society Institute (OSI) for another one-year, the project was scaled up to AIC Kapsowar, AIC Kijabe, Tenwek and Friends Kaimosi hospitals, bringing the total number of project sites to 15.

As at 2017, the project had been scaled up to 10 additional sites, bringing the project sites to 25 located in 18 counties in Kenya.

The additional 10 sites are: AIC Githumu, Oasis Medical Centre, Kilifi, Nyanchwa SDA Hospital, AIC Lokichoggio Health Centre, AIC Kalokol Health Centre, Mulango AIC Health Centre, AIC Nzombe Health Centre, Tei Wa Yesu Family Care Centre, AIC Kiu Health Centre, AIC Mukaa Health Centre, Ng'iya Health Centre and ACEF Ena Hospital.

CHAK HIV and Human Rights project sites by county

County	Health facility	County	Health facility
Kiambu	PCEA Kikuyu hospital, AIC Kijabe hospital,	Kitui County	Mulango AIC heath center, AIC Zombe, Tei Wa Yesu health center
Muranga	AIC Githumu hospital,	Makueni County	AIC Kiu health center, AIC Mukaa health center
Nyeri	Tumutumu hospital		
Meru county	Maua Methodist Hospital		
Tharaka Nithi	PCEA Chogoria hospital		
Mombasa	ACK Kaloleni hospital, OASIS hospital	Homa bay	ACK Kendu bay hospital
		Kisumu	ACK Maseno hospital Ngiya health center
Bomet	Tenwek mission hospital	Elgeyo Marakwet	AIC Kapsowar mission hospital
Kericho	AIC Litein hospital	Bungoma	Lugulu Mission hospital
Kisii	Nyanchwa SDA Hospital	Kakamega	Friends Jumuia hospital
Turkana,	AIC Lokichogio, AIC Kalokol	Embu	ACF Ena hospital

Project goal and objectives

The overall project goal is to improve HIV and AIDS care and treatment outcomes and quality of life by increasing the protection and realization of human rights and access to justice for PLWHA.

Objectives

1. PLWHA empowered to demand and defend their human rights and demand better quality health care services in order to achieve better treatment and care outcomes and improved quality of life
2. Health care workers offering quality and humane health services as a result of integrating human rights into treatment and care of PLWHA.
3. The socio – economic status of PLWHIV is improved as a result of social economic and cultural emancipation and empowerment originating from the project
4. Health care workers are effectively and sustainably linked up to community mechanisms for reporting and registering client human right abuses and disputes reported to them in the course of their work while respecting the confidentiality of clients.
5. Capacity of community social structures and systems is built to ensure the community plays a pivotal role in effective response to and resolution of disputes involving PLWHIV
6. Effective, accessible, affordable and sustainable linkage mechanism between the community and collaborating legal practitioners and agencies for aiding legal and human rights disputes irresolvable at the community level are set up and are functional in all the project areas.

Trainings and awareness creation critical in reducing rights violations

Capacity building and awareness raising has been a large part of the CHAK HIV/AIDS and human rights project. At the project's inception, several gaps in human rights awareness became obvious. These gaps were identified at both the community and health facility level. Among the gaps highlighted at project inception were:

1) Most of the target participants were not aware of the rights they had under the law. They were also not aware of the main civil society organizations that provided free legal and other supportive services to victims of gender-based violence and other forms of human rights violations in Kenya.
2) HIV/AIDS widows and orphans were the most vulnerable to human rights violations, particularly with respect to their right to own and inherit property. Those most likely to violate their rights were their extended family members.
3) More often than not, cases of human rights abuse were reported to the area chiefs and village elders who did not provide much assistance, as they tended to be patriarchal.
4) Many of the PLWHIV noted that they were very afraid of openly discussing their HIV status with their family, friends and colleagues. They attributed this to the fear of HIV-related stigma and discrimination from members of the community.
5) Some of the local churches had greatly contributed to the stigma and discrimination faced by PLWHAs. For example, a pastor, was ex-communicated from his local church after he disclosed his HIV status to the congregation. Additionally, some church leaders refuse to solemnize marriages in which either one or both persons were HIV positive. Some of the church leaders would send couples wishing to get married for a HIV test. The couple was required to bring their test results back to the pastor, constituting a violation of the right to privacy. Some local churches had refused to openly discuss HIV/AIDS during church services thus creating the impression that it was a disease that only affected those who were sexually immoral such as commercial sex workers, as opposed to the family in general.

A HIV/AIDS and human rights TOT training in progress (top) while (bottom) a focus group discussion at AIC Litein Hospital. The focus group discussion was used to raise awareness on human rights violations and also gauge the level of knowledge among health care workers.

At inception, the following needs

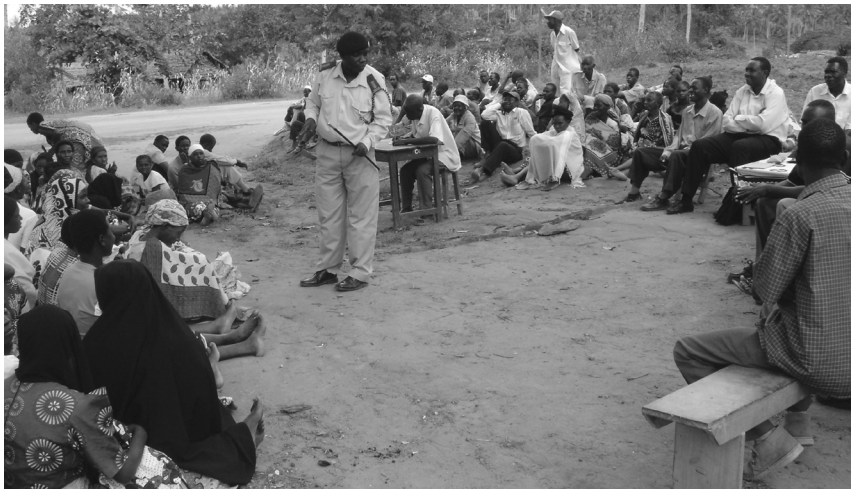
»» Page 11

Trainings, awareness creation critical

«« From Page 10

were identified to strengthen the project for impact at the health facility and community levels:

1) The need to train health providers involved in HIV/AIDS treatment and care in each site, then create awareness among the PLWHAs.
2) The need to train community health workers who were constantly with the PLWHAs in the community. It was therefore important that they were sensitized on the rights based approach to HIV/AIDS treatment and care.
3) The importance of training young people who are not HIV positive but are involved in community outreach activities such as drama
4) Need to sensitize community opinion leaders such as church leaders, councillors, area chiefs and village elders as well as the local police and administration police, as it was imperative that they had the necessary information to support PLWHAs in their respective areas.



(Top) Raising awareness of the human rights of PLWHIV during a chief's baraza. The Provincial Administration and opinion leaders were trained in HIV and human rights and became active advocates during the project implementation period. They were also trained in Alternative dispute resolution.
(Bottom) A football match to raise awareness among the youth and local community in Mtwapa, Kilifi.

HIV/AIDS and human rights TOT trainings

One aspect of TOT trainings targeted PLWHIV who were drawn from various support groups in the hospitals. Participants in the trainings were required to have completed secondary school education (O-Level) and have a demonstrated interest in issues pertaining to HIV/AIDS and human rights.

At least 75 per cent of all support groups in each facility were represented in the trainings. Most trainees were community health workers. The community health workers trained have been instrumental in educating their respective communities on HIV/AIDS and human rights. Others work as adherence counsellors and are well placed to engage in human rights advocacy in their respective communities.

Follow-up visits were conducted after the trainings to evaluate implementation by the TOTs and identify best practices and challenges.

Training of health care workers in project sites

In addition to the above on-site TOT trainings for PLWHIV, CHAK also trained health service providers including clinical officers, nurses, VCT counsellors and adherence officers. Health care workers were trained on the human rights-based approach to health care and on legal aid in order to assist health facilities integrate human rights into their community outreach services, an integral part of their regular health outreach programme. The medical professionals would also be instrumental in integrating human rights to the existing HIV/AIDS and other services in their health facilities. In these ways, the health service providers were in a

»» Page 12

Trainings, awareness creation critical

«« From Page 11

unique position to change the practice both in the health facilities and communities where they would reinforce the human rights information given by community health workers. They would also act as advocates against human rights violations for PLWHIV as well as ensure correct referrals for cases brought to them. Additionally, they were required to cascade the trainings down to other health care workers.

There are better quality health care services in the implementing facilities after integrating the rights based approach to healthcare. The PLWHA have developed confidence in the health care workers who are now able to report different human rights violations in their facilities.

The health care workers are also able to solve most of these cases reported at the community level and refer to the relevant local administration the cases that cannot be handled at that level.

However, high turnover of health care workers in FBO facilities is a challenge that necessitates recurrent training of new staff.

Integrating human rights in other capacity building sessions

For bigger impact, human rights sessions were incorporated in all HIV/AIDS and other relevant trainings conducted by CHAK targeting health care workers and church leaders.

Through this approach, health workers and church leaders were sensitized on the rights based approach and thus equipped to address HIV & AIDS-related human rights issues in their respective localities.

The CHAK network is divided into four regions, each of which elects a committee to guide activities. In the course of the project, CHAK incorporated human rights sessions in some Regional Coordination Committee (RCC) meetings.

A procession to raise awareness on the human rights of people living with HIV/AIDS in Mtwapa, Kilifi County.

Local leaders' training on Alternative Dispute Resolution

Local leaders were trained on Alternative Dispute Resolution and as TOTs on legal aid and human rights for PLWHA to enable them mentor community health workers, health workers and other community resources persons on the same subject. These opinion leaders included chiefs, assistant chiefs, village elders, pastors and primary head teachers.

Refresher sessions for the opinion leaders were conducted constantly in the course of the project. The refresher courses were interactive and involved sharing experiences and performing skits on common human righta violations against PLWHAs as well as assessing application of ADR skills learned earlier to resolve the disputes.

Creating public awareness on the rights of PLWHIV

The project used several avenues to raise public awareness on human rights abuses faced by PLWHIV and the various avenues available for redress, mainly mass media, IEC materials, roadshows and community outreaches.

Mass media

Television

CHAK General Secretary Dr Samuel Mwenda and Health Services Manager Dr Cyprian Kamau were pannelists in the World AIDS Day QTV breakfast show in 2014. They outlined the health projects undertaken by CHAK in general, before narrowing down to the HIV/AIDS programme and finally knitting in the human rights issues affecting PLWHA.

The discussion brought out the key interventions of the HIV and human rights project including training in Alternative Dispute Resolution,

»» Page 13

Trainings, awareness creation critical

«« From Page 12

capacity building in human rights for health workers and community health workers serving PLWHA, outreach services, legal clinics and legal support by pro-bono layers.

Radio

In 2016, stakeholders in the CHAK HIV/AIDS including General Secretary Dr Samuel Mwenda, Health Services Programmes Manager Dr Cyprian Kamau, Legal Officer Lena Muyanga, health care workers from implementing sites as well as PLWHIV trained in HIV and human rights participated in a total of nine radio programmes on Christian broadcasting station, Hope FM to raise awareness on HIV and human rights.

Road shows

During the project implementation period, a road show was held by community health workers, health care workers, community leaders trained in ADR, local Provincial Admiration and clients at the Tei Wa Yesu CCC. Following the road show, legal clinics for PLWHA and their families were held and HTC services offered to mark World AIDS Day.

Public speeches supporting the rights of PLWHA were given by the local admiration, opinion leaders, health care workers and CHAK staff.

Another road show was held in Kilifi County to mark World AIDS Day 2016.

Community health workers, health care workers, community leaders trained in ADR, local Provincial Admiration and clients of Oasis Medical Centre came together with the County HIV/AIDS implementation team to raise awareness on HIV/AIDS.

A football match was later held at Mzambarauni Grounds. These activities were designed to attract the local community, especially the youth to receive information on HIV and human rights.

The event also saw IEC materials distributed and speeches to encourage the local community to eliminate stigma and discrimination delivered by CHAK, Oasis and County staff as well as the clergy.

Performances including poems, skits and spoken word delivered messages on HIV/AIDS and human rights to the local community in the local language.

Community outreaches

Community outreaches were organized in all the project sites with the objective of increasing knowledge, positive and constructive attitudes towards human rights for PLWHAs in the general public. During the out reaches, communities were sensitized on human rights and the law with regard to PLWHAs.

Generic HIV and AIDS Workplace Policy

The CHAK generic HIV and AIDS Workplace Policy was developed in 2008.

The policy seeks to provide a comprehensive and policy-driven framework to address HIV and AIDS in CHAK facilities, so as to minimize its socio-economic impact as well as promote Christian love, compassion and acceptance of all persons, irrespective of their health status.

CHAK member health units have also been sensitized on the document.

CHAK TIMES issue 54

Call for Articles

The topic for the next issue of CHAK Times is "Human Resources for Health". We invite articles, photographs, experiences and letters from our readers on this subject. CHAK member health units are also invited to send information about the services they offer, training activities, new projects, job vacancies and other developments that they wish to share with the rest of the network.

Send your articles to:
The Editor, CHAK Times
P.O. Box 30690 - 00100 GPO, Nairobi
Email: communications@chak.or.ke

To reach the editor by February 1, 2018

Overview of cases of human rights abuses reported by PLWHIV

For Jane Karwitha (not her real name), the CHAK HIV and human rights project could not have been introduced to Maua Methodist Hospital at a more opportune time. Jane was thrown out of her matrimonial home following the death of her husband from HIV-related complications.

Due to ignorance, her in-laws said she had caused her husband's death by bewitching him. They therefore threw her out of her matrimonial home immediately after the burial.

With three children to feed, clothe and house, Jane in desperation sought help from her area assistant chief. This proved to be a futile move as the totally unsympathetic government officer told her to leave her children with her husband's family and "go get married again as she was still a young and attractive woman".

She then decided to seek help from the chief who gave her a letter to take to the village elders. But the elders would still not listen to her.

She therefore fled to Maua town where with no capital to start a business, no place to sleep and only the clothes she and her children were wearing, she was introduced to commercial sex work, the only opportunity she saw to earn a living at the time.

Having discovered she was HIV-positive and realizing that this was what had killed her husband, she also began visiting the Maua Methodist Hospital Comprehensive Care Clinic for her ARVs. Many of her fellow commercial sex workers working in Maua town were also picking their ARV drugs from the CHAK member health unit.

The commercial sex workers therefore began a support group to encourage one another and implement income generating projects with the support of the CHAK HIV and human rights project.

It was in one of the support group meetings that Jane heard about the human rights abuses faced by people living with HIV and received hope that such violations could be resolved using legal means. She decided to talk to the Maua hospital CCC Cordinator Stephen Gitonga who introduced her to the CHAK HIV and human rights project officer.

Jane was able to receive help from the project which also worked closely with the Njuri Ncheke, the revered Meru council of elders to resolve her case. She was able to receive her share of her husband's property including a commercial building and a farm, enabling her to fend for herself and her children.

Jane is just one of the hundreds to people living with HIV/AIDS who have received assistance from the CHAK HIV and human rights project following violation of their rights.

The HIV and human rights project has been working with CHAK health facilities that offer HIV/AIDs treatment and care to educate and create awareness on the human rights of the PLWHA and seek legal redress for human rights violations. It aims to improve community social support systems and legal linkages to enable the PLWHA to actualize their rights within their communities and environment.

The bulk of human rights abuse cases reported during the project's implementation involved succession disputes and sexual violence against women and girls with the majority of them being reported in Nyanza, Western and Coast provinces. The charts below show the nature of cases reported during the project's implementation.

Dozens of women have been assisted to get letters of administration from the public trustee's office and

»» Page 15

Nature of cases reported during the project's implementation

No		2009	2010	2011	2012	2013	2014	2015	2016	Total
1.	Succession and disinheritance of property	58	32	105	103	125	15	10	60	508
2.	Stigma and discrimination	25	22	25	35	56	10	10	27	210
3.	Sexual violence	19	19	24	21	38	10	8	10	149
4.	Assault/physical violence	12	11	17	32	32	6	6	13	129
5.	Custody and maintenance	8	8	20	18	34	20	20	15	143
6.	Child abuse and neglect	8	7	15	25	25	15	15	23	133
7.	Others	5	19	40	48	44	13	13	22	204
	Total	135	118	246	282	354	89	82	170	1476

Human rights abuses reported

«« From Page 14

successfully restored in their matrimonial home through the project.

However, most of the cases have been quite complicated due to strong cultural dynamics. It is for this reason that CHAK teamed up with legal aid organisations and incorporated the assistance of traditional cultural structures such as councils of elders to ensure cases of human rights abuse against PLWHIV were properly addressed.

Mechanisms for identifying and resolving rights violations reported by people living with HIV/AIDS

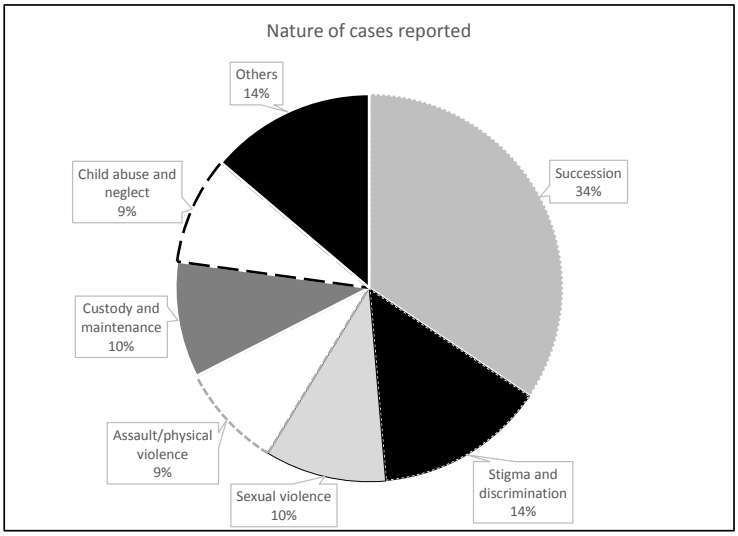
Legal clinics

Legal clinics are regularly conducted in the catchment areas of the CHAK hospitals implementing the project. The legal clinics are used as an avenue to document any reported HIV–related human rights abuses as well as facilitate identification of Public Interest Litigation cases.

The main objective of the legal clinics is to offer free legal services to persons having HIV–related legal issues, the main target being PLWHAs.

The clinics are facilitated with support from pro-bono lawyers from the respective areas where the clinics are conducted, some of whom are in private practice while others represent human rights based organizations. Among the human rights organisations that the CHAK HIV/AIDS and human rights project has worked with are Christian Legal Education Aid and Research (CLEAR) Mombasa & Kisumu, Kituo Cha Sheria Mombasa, FIDA Kisumu, Family Conciliation and Mediation and Amani Communities Initiative, among others.

The participants are given brief information on legal issues related to HIV/AIDS. The pro-bono lawyers present take them through gender, HIV/AIDS and human rights, laws protecting PLWHAs with specific emphasis on the HIV/AIDS Control and Prevention Act 2006, the law of succession and the role of the



different institutions protecting the rights of PLWHAs.

Participants are then given an opportunity to interact with the lawyers on an individual basis where they are able to share their personal legal concerns. The lawyers are expected to give legal advice or refer those cases that require urgent attention and follow up.

Cases have been referred to the provincial administration, district children's office and human rights based organizations.

Training of Trainers

Generally, the TOTs have been successfully linking those who have been violated with the appropriate Government agencies such as the local police, children's department and public trustee's office. Field visits are useful in assessing the integration of human rights by the TOTs in their CMEs, support groups and community outreach activities as well as evaluating the cases that they addressed.

Violations Monitoring Groups and Human Rights Councils

Among the key challenges raised by TOTs were threats from the public as they followed up cases reported to them by PLWHAs and failure or laxity by some law enforcement officers in responding to such cases. It was therefore recommended that Violations Monitoring Groups be formed. These Violations Monitoring Groups comprising representatives from different target groups were a collaborative effort to prevent and respond to HIV related human rights violations within communities. The groups had 20 people including chiefs, assistant chiefs, village elders, church leaders and pastors, PLWHA especially those trained as TOTS and health workers. The violations monitoring groups later evolved into human rights councils whose members include the local administration, health workers and community opinion leaders.

Interventions turn tales of woe into triumph for rights abuse survivors

Anne

From being oppressed by her in-laws following the death of her husband from HIV/AIDS complications, Anne who was nearly thrown out of her matrimonial home has over the last five years become a crusader and advocate for the rights of people living with HIV in her village.

After learning about her rights in a training organized by the CHAK HIV and human rights projects at Friends Lugulu Mission Hospital, Anne decided to approach the hospital's CCC coordinator and after several meetings with her in-laws, she was allowed back into her home where she proceeded to educate even that same family that was oppressing her on the rights of people living with HIV/AIDS.

Anne has since become a crusador and advocate for the rights of people living with HIV/AIDS in her community.

Esther

Esther also faced dispossession and dis-inheritance of her husband's property when he passed away from HIV-related complications.

Her in-laws hid her husband's identification documents so she could not access his employment benefits. However, following a training on HIV and human rights at Friends Lugulu Hospital and intervention from the CHAK HIV and human rights project, she was able to access her husband's employment benefits and build her life afresh after his death.

Ruth*

Ruth, not her real name, was a victim of domestic violence until the intervention of the PCEA Chogoria Hospital human rights council.

During a meeting to resolve their domestic dispute, Ruth told the council members that her husband constantly beat her and barred her from doing business and interacting with her neighbours.

She would often flee from her matrimonial home and go back to her parent's house.

However, this began to negatively impact on her adherence to HIV medication. The couple's youngest child is also HIV-positive. As Ruth would take the child with her whenever she ran away from her matrimonial home, the child's adherence was also affected.

Concerned, the Chogoria human rights council intervened, leading the couple to resolve their differences.

However, the council members were quick to point out that in cases where a perpetrator of domestic violence goes on battering a spouse, legal intervention is always sought.

Sexual predators arraigned in court

In one of the cases identified by the project, a girl of 13 years was repeatedly defiled by a 70-year-old man. The man was arrested but later released by the police for no justifiable reason.

The girl was infected with an STD and the HIV test turned positive. The CHAK legal officer in the company of the girl's guardian visited Luanda Police Station to establish the reason why the alleged suspect had not been arrested and arraigned in court.

After consulting with the officer in charge of crimes at the station, the accused person was arrested and arraigned in court.

TOTs from Oasis Medical Centre, then Zion Community Clinic, also identified a 14-year-old girl who was defiled by her step father and infected with HIV.

The accused person was arraigned in court and charged with deliberate transmission of HIV contrary to Section 26(1) of the Sexual Offences Act. A Lawyer from the Ministry of Justice, National Cohesion and Constitutional Affairs in Mombasa watched brief on behalf of CHAK.

The TOTs from Oasis also reported that a woman had been sexually assaulted by her husband.

The man was arraigned in court and the woman was able to testify during the hearing. However, this was followed by several adjournments which the client found very expensive and time consuming.

She therefore decided to withdraw the case despite several attempts by lawyers from CLEAR Mombasa, who had been watching brief on behalf of CHAK, to convince her otherwise.

In 2010, three cases of sexual violence were successfully litigated and the perpetrators jailed. The cases were identified by the TOTs with the assistance of their HIV site coordinators and CHAK'S legal officer.

»» Page 17

Impact of rights based approach on negative culture and spread of HIV

By Edward Keke Miller, Kendu Bay Adventist Hospital

Introduction

According to the Kenya HIV County Profiles 2016, HIV prevalence in Homa Bay is nearly 4.5 times higher than the national prevalence at 26.0 per cent (Kenya HIV Estimates 2015).

The HIV prevalence among women in the County is higher (27.8 per cent) than that of men (24.0 per cent), indicating that women are more vulnerable to HIV infection than men in the County. Homa Bay County contributed to 10.4 per cent of the total number of people living with HIV in Kenya, and is ranked the second highest nationally.

The Homabay County HIV AIDS Strategic Plan conducted in the eight subcounties of Homa Bay County between September 2014 and October 2015, identified the seven main drivers of the epidemic.

Poverty and particularly food poverty/food insecurity was the most important followed by cultural, sexual attitude and behaviour; fisher- folk and fishing industry networks, lifestyle related factors, health-seeking behaviour and professional related factors.

This article shall focus on negative culture and whether human rights interventions have made a difference in the role they play in the spread of HIV.

What is culture?

Culture is what defines a people, their total way of life and in its varied forms. Life experiences equally vary from one society to another.

Culture states what is proper food, modest dress as well as social customs including sensitive aspects of life like sex and sexuality, marriage and possessions among others. It is therefore an integral part of individual as well communal life.

Some aspects of culture have certainly brought more confusion, pain and fear than order in the society. Positive appreciation of culture therefore calls upon us to stop or mitigate negative cultural traits and the attendant consequences in different areas of life.

HIV and AIDS has remained a serious challenge despite the great advances in management and creation of awareness achieved three decades since HIV came to limelight in Kenya.

Among the successes recorded, PMTCT or EMCT are leading. Babies born to PLWHIV are today up to 98 per cent likely to turn out HIV negative with appropriate and timely interventions.

• HIV management has come of age, the only aspect to be addressed is the attitude

Acknowledgement and focus on other aspects like scale up of access to ARVs and related services through decentralization and equipping of health facilities, medical staff and related partners are also notable achievements.

Indeed as is often stated, "HIV management has come of age, the only aspect to be addressed is the attitude" and nobody should die of this manageable condition. Attitude, perhaps, stands as the single most challenging aspect to deal with in the management of this condition.

Culture and HIV/AIDS

Cultural orientations influence most communities' perspectives on HIV and AIDS, as the extremely religious consider it a curse from a holy God meting justice to sinners, the elitist society see it as a disease of the poor and majority plainly relate HIV to promiscuity and lack of self-control on those infected.

These depict a scenario where stigma and discrimination affect not only before the persons infected but also their close associates. The society's attitude toward the disease and the persons infected and affected have had great impact on the wellbe-

»» Page 18

«« From Page 16

Jail term for mother who abandoned infant in forest

A mother was sentenced to a one-year jail term for abandoning her baby in a forest.

The baby was rescued and taken to Jumuia Friends Hospital, Kaimosi where he received treatment. CHAK in collaboration with the hospital and the Hamisi District Children's Officer worked closely together to ensure the safety and welfare of the child.

The mother was charged and convicted of child abuse and neglect and served a jail term of one year at Kodiaga Prison, Kisumu.

Rights based approach and culture

«« From Page 17

ing of PLWHIV – either supported their wellness and care efforts or discouraged and disheartened clients and relatives alike.

Some backward trends in the society that have exacerbated the scourge include the patriarchal nature of most African societies where male predominance is not only practiced but also encouraged. This has led to little or no control over how sex is conducted, choice of care facilities and even the right to choose who one marries or accepts as a partner once the official spouse dies in some communities.

This has steadily exposed young girls and women to HIV as well as aged widows and sometimes widowers to new infections by HIV.

On the other hand poverty has entrenched cross generational sexual intercourse, where the aged wealthy population seduces younger moneyless men and women with the promise of better life and material wealth.

Human rights based approach to HIV and AIDS management

The introduction of a rights-based approach has had a cascading effect among different stakeholders in HIV/AIDS.

It has revolutionized care and management in HIV because, while conventional approach focused accurately on quality of drugs provided, accurate diagnosis and standardized treatment, a gap that had remained unaddressed over the past twenty years is now highlighted and testimonies abound of how lives of PLHIV have taken on a new positive direction.

Where individuals and communities are able to realize their rights - to education, free association, information and, most importantly, non-discrimination - the personal and societal impacts of HIV and AIDS are reduced.

Where an open and supportive environment exists for those infected with HIV; where they are protected from discrimination, treated with dignity, and provided with access to treatment, care and support; and where AIDS is de-stigmatized; individuals are more likely to seek testing in order to know their status.

In turn, those people who are HIV positive may deal with their status more effectively, by seeking and receiving treatment and psychosocial support, and by taking measures to prevent transmission to others, thus reducing the impact of HIV on themselves and on others in society.

The Homabay County HIV AIDS Strategic Plan identified the lack of respect for human rights and a gap in the criminal justice system capable of controlling crimes (such as rape, incest, sexual harassment and gender- based violence, sexual abuse) within the limits established by the law as a challenge in the response to the HIV&AIDS scourge.

The health criminal justice system at county level should be strengthened and operationalized with special emphasis on assistance to the most vulnerable groups who include women, young people, children and socially excluded/ marginalised groups like PwD and key populations.

Despite the challenges, there have been strides that have been made in addressing negative culture and its role in the spread of HIV & AIDS.

• Where HIV/AIDS is de-stigmatized, individuals are more likely to seek testing in order to know their status

At PLWHA's level

The aspect of integration as a measure to fight stigmatization has ensured that wild unfounded myths and uncertainties about HIV are done away with and greater awareness now exists in the communities where the rights based system has been implemented. There is continuous health education on:

- The responsibilities as well as rights of clients who are seeking health care services
- Linkage and various service points
- Community support group sessions where people share experiences
- Challenges

Peer education-cum- counseling has lit up the society toward greater understanding.

Consequently, some PLWHIV who were suffering in silence and even considering quitting the therapy have been empowered and strengthened to make more responsible life choices over their health.

In fact a number who were contemplating relocation to escape the stigma and discrimination have resorted to live and fulfill their own lives in spite of all else. The champions of human rights are actually an inspiration and living testimony to the adage that ART restores hope.

These empowered clients have now turned into champions of hu-

»» Page 19

Rights based approach and culture

«« From Page 18

man rights for people living with HIV within and without their villages, and are able to defend, refer, and arbitrate on simple village cases whenever rights of PLWHIV are directly abused or trampled on.

The fact that clients can boldly identify themselves, accept their status and share experiences freely depicts a great stride toward ownership of care and has boosted adherence to care. Many people are able to realize that they are not alone in the lifelong walk of therapy. This is indicated in the numbers that silently approach the champions for advice on how to be bold and carefree in societies deemed discriminatory.

The local Human Rights Council has also had a great impact in improving the protection of the rights of PLWHAs especially against retrogressive cultural practices. The council is of comprised health care workers from the clinic, respected opinion and community leaders' and peer educators.

Patients that are referred from the Comprehensive Care Clinic, (CCC) clinic to the council are confident in the Alternative Dispute Resolution (ADR) process as a means of achieving justice and having their rights protected.

Some of the matters that have been referred and resolved by the local human rights council have included:

- Widows almost losing their inheritance and being evicted from their homes to pave way for marauding in laws to grab their parcels of land - often their only means of livelihood
- Early marriages
- Insults hurled PLWHAs by family and neighbors.

In one case a widow was dispossessed of her land, cattle and even had her house demolished after the demise of her spouse from HIV-related complications. Her crimes allegedly included infecting their son and bewitching her husband to stop him from marrying a second wife despite her barrenness. She was 65 at the time she presented this case to the human rights council. Quick intervention by the council saw her receive help from the deputy subcounty officer having failed to get help from both her assistant chief and chief.

Community outreach session on HIV and human rights in progress.

Another case involved a 37-year-old widow whose in-laws were gradually encroaching on her farm. Her children were ostracized because of her HIV status and their relatives incessantly threatened to disinherit them saying their mother had caused their father's death after infecting him with HIV.

Fortunately she was informed enough to seek for redress from the local administrators who sided with the husband's relatives making her life even more difficult. She then approached the council which referred her to the courts. Though she is yet to get justice, her inlaws have stopped mistreating her.

Two last cases sadly exposed widows to rights abuse and saw them infected with HIV after undergoing wife inheritance rituals. In the first case, a young widow had to have sex with a 'chosen' inlaw in order to officially start living in her own homestead, a custom commonly termed in the local dialect 'yaw pacho' loosely translated as 'opening a new home'.

The other woman was forced to sleep with a man for other rites and customs to be properly fulfilled in the homestead. Needless to say, her will or consent was not respected and the man's HIV status was a topic none wanted considered. The woman had to cooperate lest she be sent packing.

These among other cases depict a male dominated society where the females mostly

»» Page 20

Rights based approach and culture

«« From Page 19

find themselves on the receiving end with many disenfranchised of their basic rights. This male domination spreads across a much wider spectrum including preference for boys in education and social support, community support for needy cases, association of bad omen with women, step children from other unions, among other examples.

Following the implementation of the CHAK HIV and huamn rights project, community health workers are reporting heightened respect for human rights and lowered levels of discrimination in their areas of coverage.

The community is now appreciating the full potential that PLWHIV possess. The once discriminated against group has earned itself a place in decision making on issues affecting the lives of PLWHIV and privileges which were earlier on denied blatantly based on the negative attitude communities held against those known to be HIV-positive.

At facility level

At facility level, some health care workers who ignorantly mistreated and disenfranchised their clients have adopted more friendly, dignified interactions during clinic visits as opposed to earlier years when clients were identified by their opportunistic infections, would be discussed in the hearing of others, and sometimes referred to in a derogatory manner.

The initial view of 'victims/patients' has been replaced with the more dignified 'client' view. The consistent improvements recorded by clients and relatives in the health status of PLHIV has contributed to this shift. Clients, health care workers and relatives all feel satisfied with the results of this intervention.

A remarkable mental shift has thus occurred with dignified, considerate and participatory approach to ART traceable to the introduced emphasis on the rights of PLHIV as they seek medical attention.

At community level

At communal level, the inclusion of opinion leaders, local administration and the laity in quest for holistic care has given credence to the significance of PLHIV in the society.

Their part in socio-economic development is now recognized and their input is considered as valuable as anybody else's. To a great extent this is attributable to the creation of the local human rights council. The council has also enhanced accessibility to benefits associated with alternative dispute resolution and occasional legal redress through facility legal experts and referrals by CHAK.

Some cases have been followed through to positive ends. Regular meetings and sessions held by the team have created a protective environment dissuading careless discriminatory remarks and actions since the wider society is aware of the council whose key goal is to mitigate and eliminate discrimination and stigmatization to improve the quality of life for PLWHIVs. The inclusion of a government face, (local administrators) in the team has given authority to the sessions and processes pursued so far.

The emphatic view of rights and responsibilities in HIV care has challenged the status quo with step-parents, orphans and the vulnerable in society getting proper attention. Disclosure is more carefully conducted and client education is given due priority. Assessment is more objective with areas earlier deemed insignificant coming to light.

Some facets of HIV management recently brought into sharp focus directly and indirectly by the rights-based approach include discordance, differentiated care model, psychosocial assessment, gender based violence, PEP and Prep.

Cases are now reported of rights violations in families, communities and clinic for redress, a milestone in the efforts geared toward achieving social support and quality health care. As a result of this, many families that were almost crumbling have been supported to get back together, children taken back to school and victims of violence identified and offered special support which all impact positively on persons living with HIV and their families.

Adherence has improved since most clients are able to understand and even ask questions regarding their treatment, laboratory tests and participate in identifying their appointment dates. Their care is thus made meaningful and defaulters have reduced.

One category of clients changing for the better is adolescents living with HIV. They are less stigmatized now and they not only attend their appointments but also make suggestions as to how they would like their cases handled including developing youth friendly clinics.

Conclusion

It is therefore true that holistic care entails physical, mental and spiritual wellbeing so that any efforts leaving out one aspect of the

»» Page 21

Social and economic support key in effective rights based approach

By Francis Vue - Oasis Health Centre, Kilifi

Introduction

According to the Kilifi County HIV AIDS Strategic Plan, the county is classified as medium HIV county according to the National HIV&AIDS Estimates, 2014. With an estimated population of 1.3 million people, approximately 22,606 persons were living with HIV by 2015, according to the National HIV County Estimates.

The county HIV prevalence during the same period was 4.4 per cent, slightly lower than the national prevalence of 5.6 per cent.

The rate of poverty in Kilifi County is very high. According to Kenya National Bureau of Statistics Kilifi County is ranked number 34/47 counties from the richest to poorest ranking. It is against this backdrop that Oasis Medical Center exists and serves.

A high number of clients who visit the facility are living with HIV/AIDS. In the rural areas of Kilifi County the level of stigma is high compared to those living in other urban areas.

Oasis has used a multi-pronged approach to ensure that most comprehensive care clients' adhere to their medication, which has resulted in improved quality of life for the PLWHIV.

However, the staff at Oasis Comprehensive Care Clinic noted that roughly 60 per cent of people living with HIV/AIDS were not financially, socially, emotionally and economically stable which led to poor adherence to their medication.

Oasis Medical Centre social group

Bottom: Oasis Medical Centre social group meeting in progress.

Top: Tie and die fabrics and detergent made by the Oasis Medical Centre social group.

One of the major ways to ensure that adherence was observed and maintained was the formation of a social support group.

The group was started in 2008 with less than ten (10) members. During that time, the home-based care team visited the clients in their homes. The purpose of the visits was to support the clients spiritually, emotionally, socially, and economically and to empower their care givers with health talks on issues including transmission and prevention of HIV/

»» Page 22

«« From Page 20

human being are bound to fail. The close sympathy existing between the mind and the body must be taken into consideration especially when addressing immunosuppression.

Key factors in health services delivery like nutrition, social support, security, education and access to health services are all enshrined in the constitution but are rarely noticed until relevant cases come to the fore.

The rights based approach has thus added value to efforts to support and reintegrate those living with HIV back into normal healthier lives.

Social and economic support is key

«« From Page 21

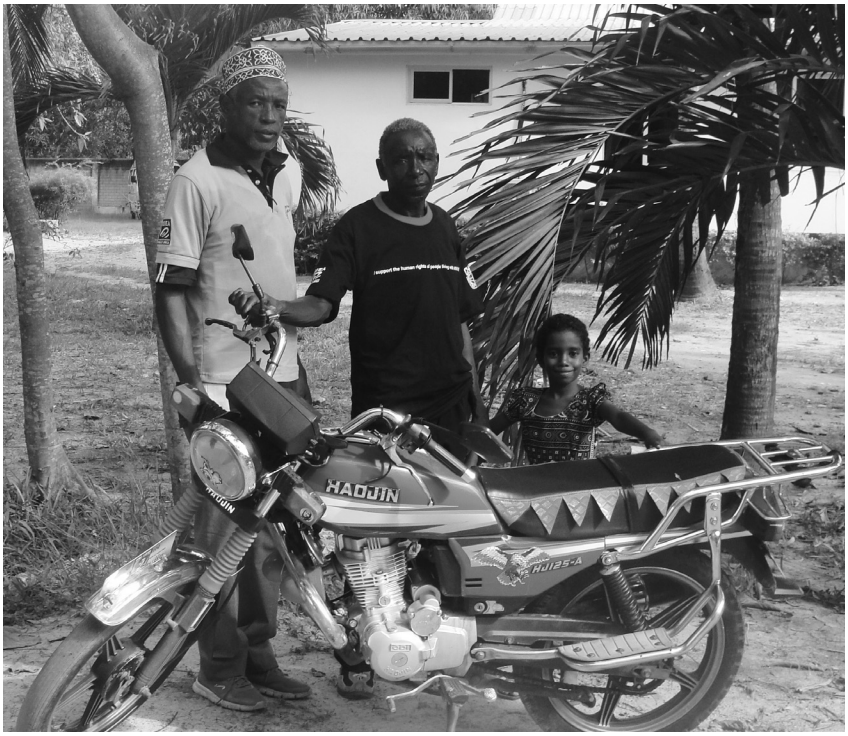
AIDS. They also encouraged the clients to join the social support group for their own benefit.

Gradually, the membership increased from 10 to 30 members, both male and female. The group was supported by two clinical officers, three home based care workers, two social workers and one psychological counselor. The group was empowered with knowledge concerning HIV management. Once in a while, with the group's consent, comprehensive care staff would invite a spiritual elder to support the members.

The group offered emotional support to the patients by offering space and allowing them to share their experiences in living with HIV. These forums were vital as they lifted the clients' self-esteem. The psychological counselor also came in handy to assist them to accept their situation and carry on with their lives.

Further, the group also offered social support. This was done mostly by the home-based care team. They encouraged the social group members to share their social life before and after knowing their HIV status. With the support from the staff the group members would come around to viewing life positively. The clients were taught that being HIV positive did not mark the end of life. They could go on with their lives if they adopted positive living which includes adherence to ART, nutrition, and sexual behavior.

The social support group also strove to offer economic support to its members. As earlier noted, many of the clients were unable to make ends meet. However, this proved challenging as Oasis was not in a position to support the group with their income generating activity.



Economic empowerment: Members of the group have improved their economic standing. This member has managed to purchase a motor bike with earnngs from the group.

However, with the aid of CHAK through the CHAK-OSI Human Rights for PLWHAs project, the group was given a grant of Ksh75,000. Economic empowerment is one of the key pillars of the CHAK HIV and human rights project.

The group started income generating activities in 2013, making soap, tie and dye clothes and detergents. These activities have helped them grow economically. About 80 per cent of the support group members have gradually improved their living standards. The group also does table banking.

Through the group projects, the members started their own small business at their homes. The grant funds were well spent enabling the activation of the group's bank account.

Through their income generating activity the group organizes a get together party every end of the year, were the comprehensive care staff are invited. It is also during this meeting that the group divides half of the interest among themselves for their Christmas vacation.

Unfortunately, over time few members have passed on due to complications arising from HIV& AIDS and a few others have relocated to other areas. The remaining group members are fully involved in the income generating activities (IGA) and are doing well up to date with a good adherence to medication and self-reliant. It is important to note that during the social group meetings, there are no HIV/AIDS issues that are discussed. Instead, members solely focus on the business that they are engaged in.

Income generating activities have also been carried out in other project sites including Friends Lugulu Mission Hospital (pig rearing), AIC Kapsowar Hospital (table banking), PCEA Tumutumu Hospital (dairy goat rearing), among others.

Using alternative dispute resolution to secure the rights of PLWHIV

BY Lena N.Muyanga - CHAK

Introduction

Conflict and dispute management mechanisms consist of Alternative Dispute Resolution mechanisms (ADR) such as negotiation, mediation, conciliation, expert opinion, mini-trial, ombudsman procedures, arbitration; traditional dispute resolution mechanisms and also formal mechanisms namely court adjudication (litigation).

Formal mechanisms of resolving disputes have not always been effective in managing conflicts. In Kenya, Courts have mainly remained inaccessible by the poor due to legal technicalities, complex procedures, inaccessibility of the Courts due to great distances, high costs and delays.

This informed the Constitution making process which recognized Alternative Dispute Resolution, including ADR and traditional dispute resolution through Article 159 2(c).

Article 27 of the Constitution of Kenya 2010, outlaws discrimination on the basis of one's health status, provides for equality between men and women and allows the use of affirmative action to redress past discrimination.

Further, The Kenya HIV and AIDS Prevention and Control Act, 2006, provides the legal framework to address HIV, providing for protection and promotion of public health, appropriate treatment, counselling, support and care of persons infected or at risk of HIV infection.

Access to justice has been recognized as being vital to the promotion and safe guarding of human rights especially for vulnerable groups in the society that are prone to discrimination such as women, children, persons living with disability and people living with HIV AIDS.

In the case of PLWHAs, access to justice is embedded in the establishment of the HIV & AIDS Tribunal. The High Court of Kenya and the HIV and AIDS Tribunal have given positive decisions that have affirmed the rights of persons living with HIV.

The HIV tribunal, however, remains out of reach for many people in need due to its geographical location and limited public knowledge about it.

Alternative Dispute Resolution in the CHAK HIV and human rights project

It is against this backdrop that the CHAK HIV and human rights project focused heavily on ADR as a means of dispute resolution and protecting the rights of PLWHAs within communities.

The project also worked with traditional resolution justice systems.

Before the advent of colonialism communities living in Africa and Kenya in particular had their own conflict resolution mechanisms.

Whenever a conflict arose negotiations could be done by the disputants. In other instances, the council of elders or elderly men and women could act as third parties in the resolution of the conflict. Moreover, disputants could be amicably reconciled by the elders and close family relations and advised on the need to co-exist harmoniously. As such traditional conflict resolution mechanisms were geared towards fostering peaceful co-existence.

However, women have always been marginalized by culture. For example, culturally, women do not inherit their fathers' property. In some communities, when a woman has no sons, she is ostracized by her family.

People Living With HIV & AIDS experience discrimination and stigma as a result of their health status. This stigma and discrimination stems from misconceptions and myths. The PLWHIV experience discrimination when it comes to land and property rights and are subjected to negative culture such as widow cleansing and widow inheritance, sexual and gender based violence as well as insults, ridicule and general exclusion by the community at large.

Role of Human Rights Councils

Human Rights Councils in the CHAK HIV and Human Rights project

It is against this backdrop of that the CHAK HIV Human Rights program was conceptualized. It was envisioned that Alternative Dispute Resolution would be a useful tool for resolving disputes that led to human rights violations of PLWHAs.

The rationale behind adopting Alternative Dispute Resolution in the project was it would serve as a useful tool given the constraints in accessing the formal justice system (courts) compared to the ease in accessing and engaging with informal systems such as village elders, pastors and other local opinion leaders.

In its early years of implementation, the project trained village elders

»» Page 24

Why alternative dispute resolution?

«« From Page 23

in its 25 implementation sites in human rights principles, especially the rights of PLWHAs and mediation skills as a tool of Alternative Dispute Resolution. The trained elders were expected to serve as a positive influence to their peers, encouraging them to respect human rights and advocate for the rights of PLWHIV. They were to be the voices of reason in the panels in which they sat.

However, patients from the Comprehensive Care Clinics in the implementing health facilities kept on complaining that their rights were being violated by people close to them, yet they did not know who to turn to. This led to the formation of a Human Rights Council in each of the project's 25 implementing sites.

The Human Rights Councils are made up of health care workers and peer educators from the CCC and respected opinion leaders from the local community. Each Human Rights Council has a total of eight members.

The members have been trained on human rights and mediation skills. Further, they were assisted in formulating an agenda on how to conduct sessions. The Councils also mapped the resources around them, identifying individuals and 'institutions' around them that could assist in protecting the rights of PLWHAs.

They were able to identify local administrative offices such as chiefs and sub county officers, local community based organizations and village elders.

How the Human Rights Councils work

The councils were first introduced to the patients in the CCC through the psycho social support groups and their mandate explained.

Patients who have issues and need intervention by the Human Rights Councils report the matter to the peer educators who double up as the secretaries to the councils. The peer educators then give the client an appointment date to appear before the council.

Training opinion leaders in HIV and human rights at Friends Lugulu Hospital.

The client seeking help appears before the council on the said date and after explaining their case leave the council to reach out to the person or groups of people mentioned by the patient. This differs from summons as the system is purely voluntary. Many have honoured the invites, mediation conducted and amicable solutions have been arrived at.

However, where the parties invited fail to appear before the council, the matter is referred to one of the institutions identified as able to protect the rights of PLWHIV. A member of the council is then tasked to walk with the patient in the journey of seeking redress for the violations experienced.

Benefits of ADR in the project

Working with elders and other opinion leaders has been a great experience for the project. The leaders have been a fountain of knowledge and wisdom for the project. Further, with the formation of the Human Rights Councils, this has eased access to justice for patients in the CCCs.

The Human Rights Councils have mediated over matters involving patients and mostly their neighbors and family members to successful conclusion. The matters reported to the councils were discriminatory in nature towards the patients.

The councils have also been a great agent of change for their localities. They have been instrumental in advocacy efforts through speaking and spreading the message of human rights and the need to respect and uphold the rights of PLWHAs.

The councils have also been important to the CCCs as they are called upon to give talks on human rights to peer support groups, educate members on their rights and how to protect and claim them.

However, a notable challenge has been the overlapping of ADR systems in localities. For example, there is a Human Rights Council in the Hospital as well as an established council of elders in the locality. Which ruling would be followed if both systems of ADR get involved in a dispute?

In conclusion, Alternative Dispute Resolution continues to be a great tool for protecting the rights of PLWHAs. However, more needs to be done in entrenching the message of human rights especially of vulnerable groups in communities.

Maua hospital steps up to deal with HIV and human rights in adolescents

By Stephen Gitonga - Maua Methodist Hospital

Introduction

Maua Methodist Hospital is situated at the foot of Nyambene ranges in Igembe South sub county, Meru County. The hospital is situated 300 kilometres east of Nairobi. Maua hospital serves a catchment area of slightly over 900,000 inhabitants. The area is blessed with very good climate that allows farming with a variety of crops being grown by the locals.

Tea is grown on a large scale in the upper zone, miraa in the middle and lower zones while maize and beans are grown in the lower zones.

Maua town is a major business hub with a heavy inflow of people coming for business. For example, traders from other parts of the County bring in cereals and milk. There is also a thriving miraa trade in Maua.

County HIV/AIDS profile

Meru County has a population of 1,455,850, comprising 727,528 males (50 per cent) and 728,322 females (50 per cent). Children below 15 years constitute 40 per cent of the population while youth aged 15-24 years constitute 19 per cent of the population (2015 KNBS Population Projections).

The Ministry of Health through a fact sheet on Adolescent Sexual and Reproductive Health Rights, recognizes the impact the youthful population has on the County's health and development agenda as it puts increasing demands on provision of services including health and education.

One of the main areas of concern in Kenya is the sexual and reproductive health (SRH) of adolescents and the extent to which their SRH needs are met.

Further, according to the Ministry of Health, about one in five (22 per cent) people in Meru County are adolescents aged 10-19 years. Approximately 11 per cent of women and 58 per cent of men reported sexual debut before age 15 in the county (KDHS, 2014).

Relationship between economic activities and the spread of HIV among adolescent girls in Maua

Certain groups in the population are more vulnerable to contracting the HIV virus because they are unable to realize their civil, political, economic, social and cultural rights.

For example, individuals who are denied the right to freedom of association and access to information may be precluded from discussing issues related to HIV, participating in AIDS service organizations and self-help groups, and taking other preventive measures to protect themselves from HIV infection.

Women, and particularly young women, are more vulnerable to infection if they lack of access to information, education and services necessary to ensure sexual and reproductive health and prevention of infection.

The unequal status of women in the community also means that their capacity to negotiate in the context of sexual activity is severely undermined. People living in poverty often are unable to access HIV care and treatment, including antiretroviral and other medications for opportunistic infections.

In the wider Maua area, the link between the economic activities and the spread of HIV is undeniable. Mostly affected are young girls who lack access to education, information and reproductive health services, often due to poverty, lack of education and the partriachal nature of the society.

The tea industry

As previously indicated, tea growing is a thriving business in Maua town. The area is served by two factories which have employed casual workers to carry out tea plucking as well as tend to the crops. This attracts many seasonal employees and individuals who come to cash in on the tea bonus money especially between the months of October to December.

The tea industry feeds the spread of HIV among adolescent girls in several ways. First, the tea is taken to the buying centres which at times operate late into the evening. This exposes young girls to sexual exploitation by men and boys who promise to protect and escort them home in return for sexual favours.

Second, when the tea bonus, often a lump sum, is released to the farmers many young girls engage in transactional sex with farmers.

These girls are not in a position to negotiate for safe sex, either due to poverty, ignorance, among other reasons. As a result they are exposed to STDs and HIV.

»» Page 26

HIV and human rights in adolescents

«« From Page 25

Miraa trade and the spread of HIV & AIDS

Miraa trade is a big business in Maua, raking in millions of shillings daily. The miraa plants are not labour intensive and mature at least fortnightly. The trade has employed many casual workers who are involved in plucking, preparing, packing and loading miraa onto trucks for delivery to the markets.

Each of these stages involves making money which doesn't require a lot of energy. With the society being deeply partriachal, men in Maua regard miraa trade as their territory. Many of them disregard the right of their children to proper care and education, failing to support their families with the money earned from the sale of miraa. These men prefer to idle away in the town during the day and go home to sleep at night with nothing for their wives and children.

Due to this behaviour, some women and young girls have resorted to directly plucking, preparing and packaging miraa, making them easy prey for men who demand sexual favours from them in order to buy their miraa. The men also promise to escort these women back home when business runs late into the night, also in exchange for sexual favours.

After packaging the herb, there is free time in which the traders engage in leisure. During this time, they visit wines and spirits outlets in Maua town, hotels as well as nyama choma joints since they have money and hope for more the following morning.

This access to easy money has lead to school dropouts and early marriages among young girls. This exposes them to HIV and STI infections since they have dropped out at a tender age when they have no power to negotiate for safe sex. It is common to find girls of 20 years with two to three children in Maua since they engage in early sex and marriage.

Further, many young men have bought motorcycles commonly referred to as 'boda boda' using the money they make from the Miraa trade. Some of the young girls have made friends with the riders to a point where they don't pay cash for the ride but pay with sexual favours, predisposing them to HIV and STI infections.

FGM, early sexual debut and transactional sex

Female genital mutilation silently goes on in the community. This has the potential to get young girls to engage in sex since they are labelled "mature women" after circumcision. This means the girls can get married and have children.

Men with money exploit the young girls for sex at a little or no payment for services offered.

School dropout rates are high in the area where the value of education is not highly regarded. The number of girls completing class eight in area primary schools is quite low. The young girls would rather go for casual labour which has immediate returns as opposed to the long term gains of education.

• Women, particularly young women, are more vulnerable to infection if they lack of access to information, education and services necessary to ensure sexual and reproductive health and prevention of infection

In the evenings in Maua town, it is common to find young girls actively soliciting for clients. Their customers are mostly the traders and truckers in the miraa trade.

Efforts by Maua hospital to tackle adolescent reproductive health challenges

Adolescents' sexual and reproductive health in Maua is complex. This is compounded by the fact that by the time the adolescents get to the health facility, they are already infected with HIV or other STIs.

The Maua CCC has formed psycho social groups for teenagers and assigned them to staff who are able to relate to and communicate with this demographic.

In these groups, the adolescents are able to discuss their day to day issues, especially the peer pressure they face. University students especially face peer pressure not to disclose their status to their sexual partners .

The counsellors explain to them that they have a duty not to put another party at risk of HIV infection as well as not to risk re-infection. They are also taught their human rights.

Adolescents who are in school face discrimination from uninformed school heads who want to deny them permission to attend their clinics and fill their prescriptions. In such instances, the facility get involved in a quest to protect the rights of the child.

In conclusion, girl child empowerment is yet to take firm root in Maua. There needs to be a greater multi sectoral push in fighting FGM and keeping girls in school to give then a chance at a better and brighter future.

Ensuring respect for the rights of PLWHIV in Turkana County

By Sammy Ikeny - AIC Lokichoggio Health Centre

Background

The Turkana are part of Nilotic tribes and constitute the second largest pastoralist community in Kenya after the Maasai.

They speak the Turkana language, which is similar to the Maasai language. The Turkana, like the Samburu and Maasai, still maintain their undiluted traditional way of life. They are distinguished as being great survivors, living in harsh and inhospitable terrain.

As with all other pastoralist tribes in Kenya, livestock, especially cattle, are at the core of Turkana culture. The Turkana people live a nomadic life, always moving from one place to another depending on the availability of pasture and water for their animals.

The Turkana people place such a high value on cattle that they often raid other tribes to acquire more animals. This may be seen as theft, but to the Turkana and other pastoralist tribes in Northern Kenya, it is a perfectly acceptable traditional custom.

Cattle raids are common between Turkanas and their neighboring tribes, especially the Karamoja of Uganda and the Pokot and Marakwet of Southern Kenya. Unfortunately, these cattle raids have increasingly become more dangerous due to an upsurge in the use of small firearms (guns and rifles).

Today, many people in the region own unlicensed firearms for their own protection. The sight of a Turkana herdsman holding a G3 (or AK47) rifle while herding his animals is not strange. Unlike other nomadic tribes, the Turkana do not have many complex customs or strong social structures. Each Turkana family tends to be self-sufficient though at times a number of families may graze their animals collectively.

Polygamy is an acceptable way of life. A Turkana man can marry as many wives as he can afford to pay bride price for. Like the Luo and the Teso tribes, the Turkana do not practice male circumcision. They also do not hold any special initiation rituals to mark the transition to manhood.

HIV in Turkana County

According to the Kenya HIV County Profiles, 2016, Turkana County has a population of 1,045,579, comprising of 542,658 males (52 per cent) and 502,921 females (48 per cent). Children below 15 years constitute 43 per cent of the population, while youth aged 15-24 years constitute 24 per cent of the population (2015 KNBS Population Projections.

The HIV prevalence among women in the county is higher (5.7 per cent) than that of men (3.4 per cent), indicating that women are more vulnerable to HIV infection than men in the county.

HIV/AIDS and poverty among the Turkana community

Poverty refers to scarcity or lack of a certain amount of material possessions or money.

Poverty remains a major challenge in Turkana County. Although the proportion of Kenya's population living below the poverty line declined from 52.6 percent in 1997 to 45.9 percent in 2005/06, in Turkana County the proportion living below poverty is at a staggering 92 percent while those who are food poor are 72.7 percent.

Multiple crises such as post-election violence, severe drought and recession during the years 2008, 2009 and 2011 are likely to have increased the poverty levels. The county's contribution to national poverty stands at 1.3 percent.

At AIC Lockichoggio, it is clear that poverty contributes to human rights violations among PLWHAs. The PLWHIV go through a lot of suffering and abuse from the community. However, due to lack of finances to even feed themselves, they are unable to take legal measures against the perpetrators of these human rights violations.

Poverty also contributes to unintended disclosure of one's HIV status. Many PLWHIV live in deplorable conditions. Often, their living quarters are extremely congested and their privacy is compromised.

Alcoholism is common in the community. Cases of people using alsoholism and drunkenness as an excuse for violating the rights of PLWHIV are common. Unauthorised disclosure and abuse are some of the more rampant human rights abuses.

Many of such cases could be avoided if each family unit had its own homestead. However, this is not possible due to poverty.

A clean and healthy environment remains a pipe dream for most

»» Page 28

Pushing for PLWHIV rights in Turkana

«« From Page 27

people in Turkana. The community, including PLWHIV get their drinking water from rivers near their homes. During the dry season, these rivers tend to dry up, leaving many families without water. Worse, many families practice open defecation. This predisposes communities, especially PLWHIV, to all kinds of communicable diseases ranging from cholera, typhoid, and amoebiasis.

Poverty coupled with HIV compromises human dignity; first one is poor, and second, majority of PLHIV go through acceptance challenges, both self acceptance and acceptance by the community, seeing themselves as not equal to others. They feel they don't deserve some benefits and therefore tend to associate themselves with people in the same situation.

Further, living in poverty denies children living with HIV right to education, and most of the time, they are neglected. The community fears to waste their resources on people they believe have no future and can die anytime due to their health status.

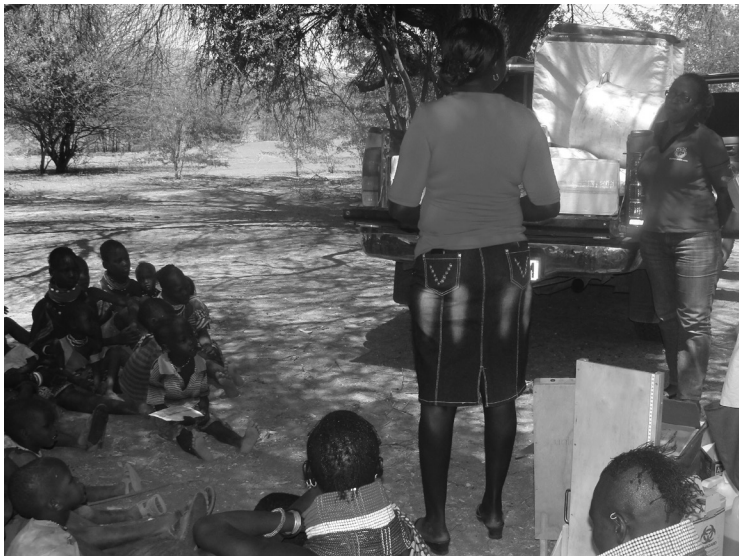
Infection with HIV is therefore perceived as a death sentence and such children are not given equal opportunities, compromising their future.

HIV/AIDS and culture in Lokichoggio

Culture refers to ideas, customs and social behavior of a particular people or society. Turkana culture allows wife inheritance and polygyny. In one way or another, this will lead to new HIV infections, re-infection with mutants, unintended pregnancy and lastly, poor health following high viral load, depression and stress.

The culture only allows ownership of property for males. For example, livestock belongs to the man, even if it is the woman who bought them.

This culture limits access to or use of such property. In case a woman is sick she must get permission from the husband to sell livestock to raise hospital fees. In addition, it is the duty of the wife to provide shelter and submit to the husband at all times.



(Top) CHAK Legal Officer Lena Muyanga speaks to the local community on HIV and human rights during an outreach.

(Bottom) Community Health Workers attached to AIC Lokichoggio Health Centre in a discussion on human rights violations in their community during a training at the facility.

Women who are HIV positive are usually advised to plan their families and take the requisite measures, with the help of the health worker, to ensure their babies do not contract the virus. However, the local culture does not allow use family planning methods, including condoms. This provides an avenue for new infections, unplanned deliveries, and in the long run, poverty.

Further, culture usually leads to stigma and discrimination. Individuals known to be HIV-positive are feared, denied freedom to associate with others due to the misplaced fear that they will also get infected.

The PLWHIV therefore face a lot of discrimination, mainly due to lack of awareness and education in the community.

»» Page 29

Pushing for PLWHIV rights in Turkana

«« From Page 28

Also, the local culture advocates for herbal medicines. There is a belief that there is no treatment for HIV in the hospital set up, hence PLWHIV are given herbs. This leads to poor health as these herbs they are not of benefit while the virus gets an opportunity to replicate. Moreover, the PLWHIV end up wasting much-needed resources on traditional doctors with no benefit whatsoever.

Culturally, the rights of women are not respected. The main social protection that a widow can get from the community is to be inherited by another man, mostly a relative of her deceased husband. This ensures the continuity of her residence and access to her matrimonial property which, according to Turkana culture, is not inherited by girls or women.

AIC Lokichoggio Health Centre Human Rights Council

Following aforementioned challenges, the CHAK HIV and human rights project was introduced at AIC Lokichoggio. Through the project, a facility-based committee was formed to address some of the issues in relation to human rights violations. The committee is composed of:

1. Focal point person
2. Peer volunteers
3. Opinion leader
4. Local administration (assistant chief)
5. Religious leader (pastor)

The focal point person is the key player in the committee, because majority of affected people will not come out openly to report human rights abuse. Additionally, many of them do not know where to report such abuses so they keep silent.

The project has created awareness among CCC clients through psychosocial support meetings and peer volunteers to encourage them to report cases of rights violations. Due to this efforts, approximately 2-3 cases of human rights violations are reported every month.

Most of the cases are handled by the committee, although complicated ones are referred to legal systems such as the police and provincial administration, e.g. chief's office.

This intervention has been a huge relief for the locals and an eye opener on how to seek justice. The human rights committee has been well appreciated by the local community.

Speaking for the widows

Ms. Akal Lorumor, a widow from Lorus Village, Nanam ward summarized the situation of Turkana widows when interviewed during a community outreach

After the death of her husband, a woman experiences many problems caused by some of the traditions. Turkana culture requires that a widow be inherited and her deceased husband's property be confiscated from her.

Ms. Akal Lorumor during the interview.

A widow has no value in our culture. We (widows) are called ngapuser, a derogatory term. We are discriminated against even by fellow women who have husbands.

This situation makes us lonely and obviously forces most widows to get into unwanted re-marriage (being inherited by their husbands' brothers). If one refuses to re-marry, she can be sent back to her family empty-handed.

Sometime in the past, they wanted to inherit me as a widow. They organized a clan meeting. But I refused and told them that I would not allow that happen.

I won! And look, here I am, with my own house, cows and have managed to send my children to school. My first born is in AIC Kangitit School. Other widows are in trouble every day, but I am trying to educate them 'behind closed doors' because it is dangerous to spread this 'poison' of awareness to others. The whole village will be against me.

Role of health workers in providing rights based care to PLWHIV

Introduction

A human rights-based approach to health specifically aims at realizing the right to health and other health-related human rights.

Health policy making and programming are to be guided by human rights standards and principles and aim at developing capacity of duty bearers (health care workers) to meet their obligations and empowering rights-holders (patients) to effectively claim their health rights.

Protection of human rights is an integral component in the response to Human Immunodeficiency Virus (HIV). The high degree of stigma and discrimination associated with Acquired Immune Deficiency Syndrome (AIDS) has made human rights protection not only a priority to ensure the rights of people living with and at-risk of HIV, but to address public health goals as well.

On the other hand, the failure to meet public health goals represents a serious threat to the human rights of people affected by HIV. Successful responses to HIV depend upon articulation of models that drastically increase use of HIV testing, prevention, treatment and support services and do so in ways that promote human rights protection, reduce stigma and discrimination and encourage the sustained engagement of those directly affected by HIV.

HIV testing raises concerns about stigma and infringement of the rights of HIV-infected people. Central issues are autonomy and privacy, or, clinically, informed consent and confidentiality. Outside of health care, diagnosis of HIV infection is self-initiated.

In clinical practice, consent is assumed for non-invasive investigations that form part of standard care. The provision of information with ability of patients to decline HIV testing, informed right of refusal or the opt-out approach, balances autonomy with usual medical practice and meets ethical standards of informed consent.

- **Protection of human rights is an integral component in the response to Human Immunodeficiency Virus (HIV)**

How a health worker can provide rights-based care to PLWHIV

Health care workers can practice rights based approach to health care provision by:

1. Care and support

a) Giving and supporting services to those who are most susceptible to infection e.g. commercial sex workers, intravenous drug users, children e.t.c.

b) Informing people living with HIV/AIDS about their rights and available treatment

c) Supporting and encouraging those infected to participate in the community

d) Comforting those who are sick through counseling, home visits and other programmes

2. Public education

a) Conducting trainings on the rights of PLWHAS in respective health units

b) In order to be an effective trainer, the health care worker ought to:

a) Prepare well before hand

b) Be able to communicate effectively and clearly to the audience

c) Be able to read the audience

d) Adopt a participatory approach (posing questions to the audience, using group activities, engaging them in discussions e.t.c.

3. Monitoring and documenting human rights abuses related to HIV/AIDS

1) Health care workers also should monitor and document human rights violations through interviewing and talking to their patients. To get the most information from the patients, the health care worker should work at:

a) Establishing a friendly environment

b) Avoiding being judgmental, arrogant and critical

c) Empathizing with the patient

d) Communicating clearly

e) Maintaining confidentiality

2) Documenting reported human rights violations

Properly record all the information for purposes of referral and follow-up

3) Health care workers may not be in a position to assist in all the matters that are brought to their attention. Instead, they ought to be aware of the places that they can refer their patients for legal assistance. These places include:

»» Page 31

AIC Kijabe College of Health Sciences holds annual graduation

By Anne Kanyi - CHAK Secretariat

AIC Kijabe College of Health Sciences held its annual graduation ceremony on Friday December 1, 2017. During the ceremony, a total of 97 students graduated in various disciplines including:

- Scrub techs
- KRCHN Basic
- KRNA
- ECCO

The guest of honor at the event, Dr Vincent Ogutu, urged the graduands to go out and serve others with humility, following Christ as their example. The graduands took the Hippocratic Oath to provide the best quality health services in their communities. Among the guests at the event were AIC Kijabe Hospital staff and Board members, representatives from the Nursing Council of Kenya, among others.

The college which is a department of AIC Kijabe Hospital was founded in 1980. Since its inception, the college has expanded and has trained over 1,200 highly qualified professionals who are functioning both locally and internationally.

The graduation ceremony in progress.

In 2006, a curriculum was developed for an Advanced Diploma in Nursing Anaesthesia (KRNA). This was the first programme of its kind in Kenya. Other curriculums that have been developed for higher diplomas in nursing include higher diploma in Perioperative Nursing and Critical Care Nursing.

Nursing education is accredited by the Nursing Council of Kenya (NCK).

A diploma in Clinical Medicine and Surgery program was accredited by COC in the year 2015 and the fist class admitted in September 2015 while the curriculum for the higher diploma in Emergency and Critical Care for Clinical Officers was accredited in early 2017.

»» Page 32

Health workers' role in rights based care

«« From Page 30

- The Children's Department
- The police
- The Provincial Administration i.e. the DC and the DO
- Area chief
- Administration Police
- Public Trustee's office
- Paralegals, CBOs, FBOs and NGOs in each area that promote the rights of PLWHAS

Examples of human rights violations faced by PLWHAS include but are not limited to:

a) Human rights abuses that are criminal in nature:

- Murder
- Physical assault
- Sexual violence
- Arson and malicious damage to property
- Coercion e.g. early and forced marriages, sexual exploitation e.t.c
- Child labour

b) Human rights abuses that are civil in nature

- Unfair discrimination
- Violation of human rights relating to health e.g. breach of confidentiality, lack of access to proper treatment, unethical research etc.
- Wrongful dismissal from employment
- Disinheritance of property

AIC Kijabe holds annual graduation

«« From Page 31

The clinical Officers' education is accredited by the Clinical Officers Council (COC).

AIC Kijabe College of Health Sciences currently offers the following academic programs:

1) Kenya Registered Community Health Nursing (KRCHN- Basic) Diploma in Nursing

Duration: Three years, six months.

Admission requirements:

The minimum academic entry requirements for KRCHN are:

- C plain and above in KCSE
- C plain in English or Kiswahili
- C plain in Biology or Biological sciences
- C- (minus) in Mathematics or Physics or Chemistry.

There are two intakes every year, one in January and the other in September.

2) Kenya Clinical Medicine And Surgery (KCMS)

Diploma in Clinical Officers course Duration: three years

Admission requirements:

The minimum academic entry requirements for KCMS are:

- C plain and above in KCSE
- C plain in English or Kiswahili
- C plain in Biology or Biological sciences
- C- (minus) in Mathematics or Physics
- C- (minus) in Chemistry.

There is one intake every year, in September.

3) Kenya Registered Nurse Anaesthesia (KRNA)

Higher Diploma in Nurse Anesthesia course

Duration: One year, six months

4) Kenya Registered Periopeartive Nursing (KRPON)

Higher Diploma in Perioperative Nursing course

Duration: One year

5) Kenya Registered Critical Care Nursing (KRCCN)

Higher Diploma in Critical Care Nursing course

Duration: One year

Admission requirements

The minimum academic entry requirements for KRNA, KRPON and KRCCN are:

- Must have qualified as a KRCHN/ KRN/KRNM/BSCN
- Have at least two years of clinical experience

There are two intakes every year, one in March and the other in October.

6) Emergency And Critical Care For Clinical Officers (ECCCO)

Higher Diploma in Emergency and Critical Care for Clinical Officers

Duration: One year, six months

Admission requirements

The minimum academic entry requirements for ECCCO are:

- Must have qualified as a Clinical Officer
- Have at least one year of clinical experience

There are two intakes every year, one in March and the other in October.

7) Operation Surgical Technician (OST)

Certificate in Operation Theatre Technician Course

Duration: One year

Admission requirements

The minimum academic entry requirements for OST are:

- Must have finished form four with a grade of above D+ in KCSE

There are two intakes every year, one in February and the other in October.

In 2000, the college made a major leap by upgrading the certificate level programme to diploma curriculum. This was an upgrading programme which trained certificate nurses to diploma. In 2004, basic training in KRCHN was started.

Focus on CHAK Annual Health conference and Annual General Meeting 2018

The last CHAK AGM proposed that the 2018 Annual Health Conference and Annual General Meeting be held on 24-26 April, 2018, at the AACC.

Registration fee per participant is as follows:

- CHAK member Hospitals – Ksh5,000
- CHAK member Health Centres – Ksh3,000
- CHAK member Dispensaries and CBHC programmes – Ksh2,000
- CHAK member Medical Training Colleges – Ksh3,000
- CHAK member Churches and Church Health Programmes – Ksh2,000
- Non members may be allowed to attend at a registration fee of Ksh15,000

Members are reminded to update their annual membership subscription to be eligible to vote at the AGM as per the provisions of CHAK Constitution.

Payments may be made by cash deposit, cheque or Mpesa using Pay Bill No: 882350, and for the Account Number –please enter name of the Member Health Unit

For further details please contact The General Secretary, CHAK.

the Samaritan

A good samaritan stopped to help a stranger. he took on the burden of caring for someone he did not know. If you have a burden that you cannot bear on your own, share it with the Samaritan. Send your questions to:

The Samaritan, CHAK Times, P.O. Box 30690 - 00100, Nairobi. Email: communications@chak.or.ke

Dear Samaritan,

I am a parent of two teenagers. My communication with them has been very poor. I tell them not to watch TV the whole day but this seems to be falling on deaf ears. Sometimes they refuse to eat food prepared by my house help. Recently the younger one who is in form one refused to go back to school at the beginning of the term and insisted on a tranfer. What can I do to improve communication between my children and i?

Concerned parent

Dear concerned parent,

You sound frustrated because you are not able to communicate with your teenagers effectively. For you to communicate with your teenagers you need to become good friends. Talk to them as opposed to talking at them and speak their language.

You also need to spend a lot of time with them. You can do some activities together, for example cooking, playing or walking. Have as much fun with them as possible.

In addition, try as much as possible to talk to them when both of you are calm to enable communication to take place. Practice good communication skills like active listening, observe non-verbal communication and encourage them to talk as much as possible.

There is a great need to appreciate even the small things that your child does. That way, you build their self- esteem and help them become more responsible.

When you tell them not to be glued to the TV the whole day, are you proposing some alternative activities that they could do to keep themselves busy? Teenagers have a lot of energy and if not directed in the in the right way, they may end up engaging in some unhealthy behavior.

You may have to teach them some life skills to ensure they understand how to deal with the challenges of life.

When you say that sometimes your children refuse to eat food prepared by your house help, what do you really mean? Is your house help a good or poor cook? Do you like the food prepared by her/him? Most teenagers usually like junk food and you as a parent should discourage this and offer a healthy diet. You also teach them why junk food is not healthy for them.

You could discuss a meals timetable together with your house help and your teenagers, and ensure they are reasonable and realistic as they plan. Additionally, have the teenagers prepare a meal which you can all enjoy. Let them prepare what they like eating once in a while.

As for the one who is insisting on a transfer, you may have to find out what could be making him hate his current school. Is he being bullied by other students? May be he does not like the food in this school, or the school is far from home, What really make him hate this school?

Young people usually experience peer pressure. He/she could be getting influenced by his age mate. He may want to be with his friends as opposed to being around strangers. Listen to him and try to help him cope as much as possible.

As a parent, do not allow your children to dictate what they want to eat, where they want to go, who should cook for them, which school they want to go, etc. You must stand firm and take the leadership position in your house.

DR. CHAKO-BURE

Jokes... jokes... jokes...

Brothers and sisters

After explaining the commandment to honor your father and mother, a Sunday School teacher asked her class if there was a commandment that teaches us how to treat our brothers and sisters.

One boy, the oldest in his family, immediately answered, "Thou shalt not kill.

Let's share a drink

A priest and a rabbi are in a car crash and it's a bad one. Both of their cars are demolished but amazingly neither one of them is hurt. After they crawl out of their cars, the rabbi says, "So you're a priest. That's interesting; I'm a rabbi. Wow, just look at our cars! There's nothing left, but we're unhurt. This must be a sign from God that we should meet and be friends and live together in peace."

The priest replies, "Oh, yes, I agree. It's a miracle that we survived and are here together."

"And here's another miracle," says the rabbi. "My car is destroyed but this bottle of wine didn't break. Surely God wants us to drink the wine and celebrate our good fortune," he says, handing the bottle to the priest.

The priest nods in agreement, opens the wine, drinks half of it, and hands it back to the rabbi.

The rabbi takes it and puts the cap back on.

"Aren't you going to have any? asks the priest.

"Not right now," says the rabbi. "I think I'll wait until after the police make their report."

Question and answer

Q. Where is medicine first mentioned in the Bible?

A. When God gave Moses two tablets.

Food for thought

1. No one is listening until you make a mistake
2. Why is "abbreviation" such a long word?
3. Borrow money from a pessimist -- they don't expect it back.

Source: http://jokes.christiansunite.com

Of towels and human rights

In the physical world, demands for human rights focus sorely on the needs and aspirations of the individual. They are about the 'self' and what is due to self. Whereas this is not necessarily wrong, there is great contrast between human rights according to the world and 'human rights' according to the gospel of Jesus Christ.

One of the greatest human rights in our Christian walk is the right of every human being to know Christ as Lord and Savior. Knowing Christ as Lord and Saviour enables us to receive the gift of eternal life and not perish in hell.

We are called to go out and preach the gospel to the entire world, to ensure that all have heard this wonderful gospel of salvation (Romans 10:14)

Christ gave up His most fundamental right – the right to life – so that we could enjoy that same right, shaken together and running over to become the gift of eternal life. When Christ died on the cross at Calvary, He ensured that those who believe in Him have life and have it more abundantly (John 10:10).

For us to live as true followers of Christ, we are called upon to follow His example. Many times, just like He did at Calvary, Christ gave up His most fundamental rights so that He could teach us the way of the Father.

For example, He taught us to serve rather to practice the self-entitlement we see in some instances when people demand for their rights.

Jesus is the Son of God; He is the second arm of the Holy Trinity; He is God. He was there since the beginning of time in the book of Genesis to-date and will be there to the end of time and forever. Yet when He was here on earth, He took on the lowliest of tasks including washing His disciples' feet (John 13:1-17). In order to complete this task, Jesus took of His robe, a sign of dignity, and instead wore a towel and proceeded to wash the feet of His disciples, each in turn. The towel accompanied by the action of washing His disciples' feet was the greatest sign of servitude.

When Jesus rose from the table and began to wash the feet of the disciples, He was doing the work of the lowliest of servants.

The disciples must have been stunned at this act of humility and condescension, that Christ, their Lord and master, should wash the feet of His disciples, when it was their proper work to have washed His.

Peter was profoundly uncomfortable with the Lord washing his feet, and, never being at a loss for words, Peter protested, "You shall never wash my feet!"

Then Jesus said something that must have further shocked Peter: "Unless I wash you, you have no part with me" (John 13:8), prompting Peter, whose love for the Savior was genuine, to request a complete washing. This washing, Jesus explained, represents salvation, the reason for His coming and death on the cross.

When Jesus came to earth the first time, He came not as King and Conqueror, therefore entitled to all human rights and more, but as the suffering Servant of Isaiah 53. As He revealed in Matthew 20:28, He came "not to be served but to serve, and to give his life as a ransom for many." The humility expressed by His act with towel and basin foreshadowed His ultimate act of humility and love on the cross.

Jesus' attitude of servanthood was in direct contrast to that of the disciples, who had recently been arguing among themselves as to which of them was the greatest (Luke 22:24).

The disciples' action is a mirror of many of us. We want to be recognized and be great, yet the gospel of Christ teaches us to serve one another in humility, giving up what many of us would regard as basic rights.

For example, many who have been called into the mission field will testify that they have gone without food on a number of occasions or their lives been in grave danger, all for the cause of the gospel?

Many of Christ's disciples died as martyrs and essentially gave up their lives for the gospel. Even today, there are many who are suffering greatly for the cause of Christ.

In the light of the above, we who are in Christ Jesus need to re-examine our lives and ensure we are living the humble life of service that Christ lived.

Philippians 2:3 tells us: "Do nothing out of selfish ambition or vain conceit. Rather, in humility value others above yourselves". This guides us on how we are to apply our rights as followers of Christ.