

UNIVERSITY OF NAIROBI

FACULTY OF ARTS

DEPARTMENT OF SOCIOLOGY

**ACCESS TO HEALTH CARE BY INMATES IN KENYA:
A STUDY OF LANG'ATA WOMEN'S PRISON AND NAIROBI
REMAND/ALLOCATION**

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**A Research project paper submitted in partial fulfillment of the requirements of the
degree of Masters of Arts (Medical Sociology)**

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DECLARATION

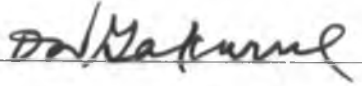
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Date 24/11/06

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2006

DEDICATION

This work is dedicated to my parents Mr & Mrs Paul Kamau Ndegwa, my son Curtis J. N. Kigera, my husband Albert Kigera, my brothers Duncan Ndegwa, Anthony Nduati & family, George Kuria & family, Caroline Waithira, Catherine Muthoni & family.

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Although the findings from this research were made possible by the participation of the key informants and the respondents, I wish to state that the responsibility of the contents entirely lies with me.

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LIST OF ABBREVIATIONS

CEDAW	Convention for the Extinction of all Forms of Discrimination against Women
CSO	Community Service Order
CDR	Crude Death Rate
FGDs	Focus Discussion Groups
GDP	Gross Domestic Product
GJLOS	Governance, Justice, Law and Order Sector Reform Programme
HDI	Human Development Index
HFA 2000	Health For All by the Year 2000
ICCPR	International Covenant on Civil and Political Rights
IMLU	Independent- Medico Legal Unit
IMR	Infant Mortality Rate
KDHS	Kenya Demographic And Human Survey
KEMSA	Kenya Medical Supplies Agency
MCH/FP	Maternal and Child Health Services and Family Planning
MDGs	Millennium Development Goals
MDR	Maternal Death Rate
MOH	Ministry of Health
NARC	National Rainbow Coalition
NSHIF	National Social Health Insurance Fund
PHC	Primary Health Care
SAPs	Structural Adjustment Programmes
SMR	Standard Minimum Rules for the Protection of Prisoners
TRIPs	Trade-related Aspects of Intellectual property Rights
UDHR	Universal Declaration of Human Rights
UNDP	United Nations Development Programme
UN	United Nations
WHO	World Health Organisation
WHA	World Health Assembly
YCTC	Youth Corrective Training Centre

ABSTRACT

The historical background of modern health care services took root from the colonial set up that was common in Africa and other developing countries at the beginning of the century. It was at this stage that sharp divisions emerged on the ability to access health care in the different socio-economic strata. All other health care facilities that were established after independence further perpetuated these inequalities as a result of which a large majority of the population could not access health care, as the health system was hospital-based. Prisons in Kenya were also established during the colonial era and the inequities in the provision of justice continued unabated. It is only in the last five years that reforms have been carried out in the prisons to ensure that the inmates' human rights are not violated and that the treatment conforms to the international instruments which Kenya has ratified.

This study identified the challenges that inmates faced while accessing health care while in confinement and how health care was provided. It sought to establish whether there were any notable differences in the health care provided amongst the male and females. The study also established the common ailments that afflicted inmates and endeavoured to ascertain whether the inmates considered the provision of health care adequate.

Since the largest health care provider in Africa and other developing countries is the state, the research sought to establish whether the state was able to cope with the demands of the entire population and the prisoners as a group with specific needs. Several extraneous factors were found to have had an effect on the entire health system, which in turn impacted on smaller health care systems such as prisons.

The study's theoretical orientation focused on the question of equity in the provision of health care amongst the inmates. This is because the lack of proper health care becomes a prominent feature of ill-health of a country's population. The focus of this study was the adult male and female inmates held in prisons falling between the ages of 18 - 40 years. The study was confined to the Nairobi province, which has prisons and custodial

institutions. This study was important because inmates are given no choice of the health care facility they would wish to attend. There was purposive selection of prisons in Nairobi area. A sample of 60 respondents was selected by way of convenience or haphazard sampling. The questionnaires were administered to 30 male and 29 female inmates and 8 key informants as 1 female inmate returned her questionnaire unanswered. The units of observation were the both male and female inmates who were in remand and those who had been convicted of their offences.

The study revealed that male inmates were worse off as far as health care provision is concerned. The male prison was congested and the medical personnel were unable to adequately cater for their medical needs. Several recommendations have been given as a guideline for enacting policies to remedy the imbalances of provision to health care amongst inmates.

1.1 Background

1.1.1. Historical Aspects

The history of modern health care services in Kenya and other developing countries in general can be traced to the well-documented colonial histories of those countries. For instance, the first modern medical establishment in Kenya was set up by Sir George Elliot in 1901 at the early stage of the colonial era. Subsequently, the Ministry of Health was formed in 1960. By the time Kenya attained its independence, its national health care system was made up of the public, private and mission health care services. These systems consisted of both modern health care system and the traditional African health care system (Mburu, 1992). The emphasis of colonial health services was hospital-based and mainly targeted the white settlers, expatriate population, military personnel and employees of large private industries. The racial policies saw the majority of the African population involved in lowly paid menial work. This meant that the average African could not access health care facilities due to cost implications.

To address these social inequalities, in 1965 the government abolished user fees for outpatient health facilities with a view to making accessibility of health care available to the whole population. However, a nominal fee of Kshs 20/= for inpatient treatment in government hospitals was retained (Mwabu, 2002). The problems of social inequalities persisted as majority of the hospitals were concentrated in urban areas, thus marginalizing the rural population (Folola, 1992).

In the 1970's a long term planning process started in Africa, culminating in the declaration of Health For All (HFA) by the World Health Assembly (WHA) in 1977(WHO, 2000). Later, many countries endorsed the declaration at Alma-Ata in 1978. The primary health care approach was seen as the strategy by which the ultimate objective of health for all would be attained. Subsequently in 1985, the WHA adopted the three-phase African health development scenario under which the district or its equivalent in different countries became the focus of health development. In 1998, the WHA, requested that the health for all in the 21st century should serve as a framework for

the development of future policy through the implementation of regional and national policies (WHO, 2000)

However, despite gains that had been made, the late 80's and early 90's saw a lack of economic growth, rising unemployment, diminishing health related sectors such as education, water supply and sanitation, emergence of new diseases such as HIV/AIDS, re-emergence of old diseases such as tuberculosis and natural disasters in most developing countries.

The demand for health services has increased despite the inadequacy of resources (Collins *et al*, 1994). An estimated 1.5 billion people are not expected to survive the age of 60 and more than 880 million people lack access to health care (UNDP, 1999). Of the more than 33 million HIV Positive people in the world, 95% live in the developing countries and most of them cannot afford the essential drugs (UNDP, 1999). In general, third world countries face challenges in guiding their economies to facilitate the attainment of the goal of “ good health for all” for their rapidly growing populations (Shauri, 2001).

1.1.2 Decentralisation and affordability

Since the 1980's, the number of health facilities consisting of hospitals, health centres, subcentres, and dispensaries in most African countries increased by one third. Although there are regional differentials due to the fact that most well-equipped health care facilities and medical personnel are concentrated in urban areas, the rural areas are reasonably served well by either the private, public, non governmental or mission health systems. This is because nearly all of the growth of health facilities has occurred in the rural areas. The district hospitals and innumerable small-scale public health facilities are crucial as they form the first contact for a large majority of the population in seeking health care services. They provide curative and preventive health services, Maternal and Child Health Services and Family Planning (MCH/FP).

In the past, government reforms included decentralization of health service delivery. Provision of health services in most urban areas in Kenya is thus shared between the central and local governments. In Nairobi, for example, the Nairobi City Council

dispensaries provide the first contact in the formal health care system as a decentralization measure. The health care system in Kenya is pyramidal in nature with the referral hospitals meant for complicated cases. The assumption is that this decentralization translates into increased efficiency in health facilities (Mushi *et al.*, 2004).

However, efforts to tackle affordability and access to health care services have been slow as the health situation has been deteriorating since independence. Factors that led to the deterioration of the health care situation included corruption, misuse of funds, lack of medical personnel, rapid population growth, rising costs in health care and poverty (Njeru *et al.* 2004). Many Kenyans are unable to access institutional health care due to their limiting economic capabilities and therefore find their life and security threatened due to high mortality rates.

In recognition that health must work in synergy with other sectors to foster equity, UNDP was instrumental in the identification of eight MDGs at the Millennium Summit in 2000. The Kenya government is a signatory of the Millennium Declaration. The sixth goal of the MDGs aims to combat HIV/AIDS, malaria and other diseases. The seventh target of these goals is geared towards reversing the spread of HIV/AIDS by 2015. On the other hand, the eighth target aims at beginning the reversal of the incidence of malaria and other major diseases by 2015. It is anticipated that if all the goals are achieved, more than 500 million people will have been lifted from extreme poverty by 2015 (UNDP, 2005).

1.1.3 Rights approach to health services provision

The Kenya prisons system was established in 1911. At that time when there were about 30 penal institutions, the inmate population was 6559 (IMLU, 2005). As at April 2005, the prisoners' population in Kenya stood between 40,000-50,000 against a recommended capacity for 16,000 prisoners. On average, prisons are overcrowded more than double capacity (IMLU, 2005).

The responsibility of management of the well being of the population is the very essence of the government (WHO, 2001). The government therefore has an obligation to provide and guarantee rights to people under its control and to formulate public health policies that ensure that everyone is healthy. Indeed all human beings have

certain inalienable, indivisible, inter-related and interdependent rights recognized in the UDHR and signed by the United Nations member states on 10th December 1948.

These inalienable rights are acknowledged by internationally recognised instruments such as ICCPR and SMR. Noteworthy, women in detention have been given special emphasis and their rights protected by the international instruments such as CEDAW (IMLU, 2002). These instruments provide that women prisoners shall not suffer discrimination and shall be protected from all forms of violence. The upshot of the signing of the international instruments and domestication of the laws means that a sick person, irrespective of whether he is free or in confinement, should be treated and be able to access health care so as to get well.

1.1.4 Health Services and Reforms

Against this backdrop, the current government is carrying out reforms in the judiciary and the prison sectors under the GJLOS programme (Kenya, 2003). The initiatives in the judiciary are intended to facilitate easy access of justice to all citizens and integrate the principles of human dignity in line with international development in penological practices. Courts are now ordering petty offenders to do community service work as opposed to being jailed. This initiative is not new having started as early as 1977 when extra-mural penal punishment was abolished and replaced with CSO under the Department of Probation and Aftercare. The objective of the CSO was to decongest prisons and provide an alternative system of rehabilitation of offenders (KNCHR, 2001).

Through the current reforms, petty offenders have been given a new lease of life as far as their health status is concerned. Depending on their financial capabilities, they have the option of seeking medical health care in health facilities of their choice. Similarly, the introduction of the open door policy has made it possible for inmates to access medical care through non-state actors. Prison warders have undergone capacity building training on the importance of human rights (IMLU, 2005). It is expected that this kind of training will assist prison warders to empathise with the plight of prisoners.

1.2. Problem Statement

The total health expenditure is mostly incurred at public hospitals followed by public health centers. Besides, an overall majority of public health expenditures are expended on

salaries in place of key patient related inputs such as drugs and other medical supplies (Kenya, 2001). As a result, prison facilities lack essential medication, specialized treatment and medical personnel (IMLU, 2004). Where inmates have to seek medical attention from the public health facilities, it has been found that most prisons do not have ambulances to transport inmates in case of emergencies. Instead, the inmates are transported to public health centres in prison lorries and buses.

Problems such as inefficiency due to mismanagement, corruption, lack of resources and misuse of funds have persisted in district health facilities (Shauri, 2001). This is despite a heavy infusion of health care resources (Amondo-Lartson, 1994)). It is for this reason that a large part of the population seeks medical treatment at referral hospitals instead of health facilities such as subcentres, dispensaries and district hospitals. Unfortunately, the congestion in the referral hospitals means that inmates are at times not treated because they have to report back to the respective institutions for their roll calls before the night shift warders take over.

Besides, while a large proportion of the population turns to alternative health care when they are unable to access institutional health care, inmates do not have that choice while in confinement and have to contend with the health facilities offered to them by the state or non-state actors. The limited choices and opportunities have an effect on the health status of the inmates. This is because any work that is undertaken by the non-state actors is purely on a voluntary basis and funds are rarely adequate. It is, however, worthwhile to note that the few non-state actors who have been complementing the government's efforts in providing health care to inmates in Kenyan prisons have to a certain extent alleviated the suffering of the inmates.

Remandees appearing in court for mention of their cases normally plead with the courts to be taken to hospital for treatment by the prison authorities. The legal requirements on the court procedures are cumbersome as a result of bureaucracies in the prisons complicated further by the delays in the judicial system (IMLU, 2004). Observations show that the requests by the remandees for court orders directing that they be taken to hospitals are on numerous occasions flouted and/or ignored by the prison authorities. These delays impact negatively on ill remandees as their cases cannot be heard and

determined. The delayed justice culminates in denial of justice thus infringing on the constitutional rights of the inmates.

Health care should be at all times be given without discriminating against any inmate (IMLU, 2002). While it is commonplace that all prisons do not ordinarily have specialised medical branches, female inmates suffer double jeopardy as they are normally unable to access specialist doctors such as gynaecologists and obstetrics as part of their essential reproductive health care needs, which often compromises their reproductive health status. However, the print and electronic media have been highlighting the reforms that have been taking place in the women's prisons following the introduction of the open door policy. Indeed, there appears to be a lot of support and emphasis given to the women's prison in Nairobi. Essentially, this has meant that the women appear to be well catered for in most of their needs. On the other hand, little help, if any appears to be directed to the men's prison in Nairobi bringing into sharp focus the discriminatory nature of provision of health care to inmates depending on their sex.

This research was therefore guided by the following research questions:-

- (a) What are the health challenges that inmates face while in confinement?
- (b) How are health services delivered in prisons?
- (c) Who accesses health care services in prisons?
- (d) Are inmates satisfied with the health care delivery in prisons?

1.3 Definition of key terms

- Convict: Any person who has been found guilty of an offence and imprisoned.
- Inmate: Any person who has lawfully been detained in prison.
- Offence: Any act which is punishable under the Kenya Penal Code.

- Prison:** A prison is any building, enclosure or place where a person is lawfully detained awaiting trial or upon conviction.
- Remandee:** Any person who has lawfully been detained awaiting trial of an offence that he has committed.
- Trial:** This refers to the process commencing with arrest, charging with offence, hearing evidence, conviction, detention or acquittal.

Objective

The general objective of this study was to examine the differences of the experiences encountered by male and female inmates while accessing health care in their respective prisons.

Specific objectives

- (a) To establish which diseases and illnesses commonly afflict inmates.
- (b) To study how health services are delivered in prisons.
- (c) To identify the factors that affect access to health care by inmates.
- (d) To establish the attitudes of inmates regarding adequacy of health provision in prisons to cater for their health care needs.

Justification of the study

Past studies had shown that a significant proportion of the Kenyan population was unable to access quality health care due to various reasons such as financial constraints or the long distances people had to cover to access health care facilities. For example, user fees had made accessibility to health care facilities out of reach of these people. In the case of inmates, the issue of accessibility of quality health care facilities was of concern as the government's health budget was overstretched. (Daily Nation 16th July 2005). Whereas inmates did not pay to access health care in prison dispensaries or public health facilities, this research nonetheless sought to show the challenges the government faced in providing health care to this particular category of people.

This study also endeavoured to establish the factors that affected accessibility of quality health care by inmates. This would assist the government address the impending factors

and come up remedial measures to ensure that all inmates were able to access adequate health care as and when the same was required. In other words, the study gave an insight on the effectiveness of the systems in prisons and collaborating institutions in providing quality health care to inmates.

The problem being investigated had implications for both male and female inmates in prisons and remand homes all over the country. Knowledge generated on the diseases and ailments that commonly afflicted inmates was and continues to be important because it can give the government an indication when allocating budgets for preventive and curative health care. Programmes often fail and resources are wasted when the efforts are directed to simultaneously tackle the many problems facing health systems. Prioritisation is therefore crucial especially where resources are not adequate to ensure that they are utilized in a more efficient and cost-effective manner.

The study showed that the overall health status of inmates was important because after serving their sentences, inmates were released back to the society for re-integration. There is therefore need for the government to come up with policy frameworks to ensure that irrespective of gender or whether free or in confinement, everyone is able to access quality health care. This is because of the emphasis in the Economic Recovery Programme that health constituted a strong entry point for poverty reduction and economic growth.

Scope and Limitations of the study

Health is a wide concept measured with a variety of health care indicators. Survival prospects measured in terms of Crude Death Rate (CDR), life expectancy at birth, Infant Mortality Rate (IMR), Maternal Death Rate (MDR), health care indicators, access to safe water, average caloric content, life expectancy rates and access to health services give a picture of the physical well-being of the people (UNDP, 1994; WB,1992). However, the focus of this research was limited to the factors that affect accessibility of health care amongst inmates in prisons in Nairobi, delivery of health care in prisons, the nature of common illnesses and diseases afflicting inmates and their attitude towards the health care provision while in confinement.

The study sought to establish whether male and female inmates had different experiences with regard to where they got treatment or whether they got any treatment at all when they visited those health care facilities. In doing so, the researcher encountered various challenges during the study. Right at the onset, there was no uniform setting as there are no prisons where males and females are confined together. This meant that the units of observation were exposed to different stimuli making it difficult for the researcher to control the environment. However, the researcher made a deliberate and important effort to study whether there were any differences in the experiences encountered by the inmates in the 2 government institutions, which are operated within the same managerial parameters.

At the Nairobi Remand/Allocation, it was not possible to conduct face-to-face interviews with the male inmates as the researcher was female. The supervisor of the Nairobi Remand School located inside the prison identified an inmate who was a highly skilled professional to distribute the questionnaires. Though the inmate did the best he could, it was not possible to carry out proper sampling of the inmates on the basis of age, education levels, whether convicted or awaiting trial as the questionnaires were distributed haphazardly. However, the male inmates were very co-operative and by 5.00 pm all the questionnaire had been completed and ready for collection..

Special arrangements had to be made for the researcher to visit the health facilities as women are not allowed within the confines of the prison. The researcher had to be escorted to all areas within the prison premises by an armed prison warden as a security measure. Ordinarily female volunteers working in NGOs that assist the prisons such as Fr Grol Foundation are only permitted to access a heavily guarded area which is outside the prison wards. The prison authorities also requested that the researcher visit the prison dressed appropriately. This excluded the wearing of tight skirts or dresses and trousers so as not to provoke the inmates some of whom had been in prison for many years without having any contact with women.

The researcher faced a major challenge when interviewing female remandees at the Lang'ata Women's Prison. Unlike in Nairobi Remand/Allocation, the researcher was not permitted to go beyond the reception area. The wardress selected the respondents on the basis of age and education levels and it was consequently not possible to conduct proper

sampling. The respondents who had been selected would wait for a few minutes on the queue and then retreat into the prison wards and fail to come back. For those who accepted to be part of the study, the face-to-face interviews were at times disrupted as the respondents attended to their relatives during the visiting hours. The arrival of the probation officers who interview remandees with a view to recommending community service took precedence over the study forcing the researcher to wait for them to finish up before completing filling the questionnaires.

The researcher noted a general apathy from the female remandees that they did not need to participate in the interviews as they would leave custody and hence it was of no benefit to them. The feeling of these remandees was that they were innocent and did not need to participate in surveys which would not help them once acquitted of their offences. The general attitude in this section of the prison was that those who came after them would take care of themselves. Indeed, the researcher had to literally beg the female remandees to complete the questionnaires. Majority of the respondents demanded that the researcher completes all the responses even when they could do so themselves. At this section, the wardress in charge could not intervene as forcing the remandees would have been interpreted as being a violation of the remandees' human rights. The researcher took 3 days to complete the questionnaires in this section of the prison. One of the remandees refused to complete a questionnaire and returned it blank without offering any explanation. This was, however, different in the section where inmates had been convicted as they expected the findings would improve their conditions in prison.

However, generally numerous interviews conducted at the Lang'ata Women's prison had made the inmates suffer from interview fatigue. The inmates felt exploited as they did not receive any monetary rewards yet they were assisting the researchers fulfil their goals. The researcher was also unable to conduct face-to-face interviews as the convicted inmates did not want their identities known by outsiders. In addition, inmates also had to complete the duties allocated to them hence it took longer for them to complete the questionnaires.

A common problem in both Nairobi Remand/Allocation and Lang'ata Women's Prison was that the researcher was not possible to access the prisons records to establish exactly how many inmates were in the two prisons at the time of the research. The reason for this

was two fold. First and foremost, this was because of security reasons. There was well-founded apprehension that such information could land in the wrong hands and be manipulated for criminal activities. Secondly, the prisons were unable to maintain proper records as offending persons could be remanded and released on the same day. In the absence of a sampling frame, the researcher had to adopt convenience or haphazard sampling. The authorities could only give numbers but not a list of names hence it was not possible to carry out random sampling. It was also not possible to get input from lawyers dealing with criminal matters. This was, however, attributed to the heavy workload that they had at the particular time.

2.1 Background

It is well recognized that prisoners cannot fend for themselves while in detention and it is the responsibility of the State to provide them with health services (Reyes, 2001). The provision of their health care is determinant on the general health care system. This is because the health care facility in prisons is a smaller subset of a larger health care system and that what happens in the larger system will impact one way or the other on the subsystem.

WHO has formulated three goals for health systems to guide policies that ensure good health, responsiveness to the expectations of the population and fair financial contribution (WHO, 2000). This means that the government's responsibility to ensure good health of its people is continuous and permanent. It is a national priority (WHO, 2001) because the healthy status of a nation is an indicator of the quality of life in a society. It is well recognized that a government that protects its people against financial costs of illnesses ensures growth of the socio-economic status of its people. The pursuit of improved standards of health has therefore become a primary health concern for most governments.

Meeting health goals requires awareness not only of the biological transmission of diseases between men and women but also the social and cultural factors that promote good health. Pertinent issues are the different health risks suffered by men and women, implications of these differences for health service delivery, the effect of differences in the availability of and access to health services and the women's ability to independently decide on the use of these services (King *et al*, 2001). These are important when designing strategies aimed at meeting the health goals. Indeed policymakers have a number of policy instruments to promote gender effectiveness. However, effective action requires that policymakers take account of local realities when designing and implementing policies and programmes (King *et al*, 2001).

Consequently, challenges facing inmates and the provision of their health care cannot therefore be established without first addressing issues that affect the general health care system, whether globally or nationally and other extraneous factors that impact on any health system such as availability of resources and sustainability of the facilities.

2.1.1 Health Care System

The largest provider in medical care in Africa is the state (Alubo, 1990). The health care of the poor who are the majority of the population is therefore financed primarily by public assistance through tax revenues and external aid to the national budgets (Korte *et al*, 1992). In most countries there are shortcomings of tax collection due to poor economic and administrative reasons (Korte *et al*, 1992). According to Terris, the facilities are generally under financed, overcrowded and have insufficient personnel (Terris, 1978).

The reality in many African countries is that the health care systems are not providing cost effective ways that would have the greatest impact on major causes of illnesses and diseases (World Bank, 1994). The nature and dimensions of the health crisis in Africa relate to the colonisation experience and structures of underdevelopment (Alubo, 1990). The unchanging colonial system has resulted in wide disparities in urban and rural health indices (Alubo, 1994). The unequal distribution of health facilities resulting in disparities of health care can therefore be attributed to political and socio-economic factors. These disparities indicate poor planning and management of health resources (Amondo-Lartson, 1994) seen in terms of bad governance and prioritization of the wrong policies.

There is poor quality of health services in many rural and peri urban areas where the large majority of the population lives. This is often as a result of shortages of qualified staff, lack of essential supplies, unreliable health data and insufficient numbers of health facilities (World Bank, 1994). The government's public expenditure is wasted while the private providers have to grapple with a huge number of unmet needs. Under these circumstances, governments have been finding it increasingly difficult to provide adequate health care (Korte *et al*, 1992) and have had to look to other players to be able to operate the health sector.

In recent years, the process of democratization and involvement of non-state actors has indirectly contributed to health development in Africa. NGO's including religious missions, international and local organizations have contributed largely to the provision of health in rural areas. These initiatives have mainly been donor funded.

In Kenya, the non-state actors provide for 94% of health clinics, maternity and nursing homes and 86% of the medical centres. Several corporate and non-governmental organizations have been collaborating to supplement the government's efforts in providing health care to the population. This collaboration with non-state actors in Kenya has been in existence since 1963 when the then President of Kenya Mzee Jomo Kenyatta "devised a development partnership between the state and non-state actors at the local level mainly through harambee" (Mbatia,1992:99).

2.1.2 Primary Health Care

Despite the many providers in health care system, the ability of people to obtain preventive care to prevent illnesses and diseases depends on the availability of efficient and equitable health systems. In most African countries, personal health care facilities reflect the countries' administrative hierarchy, which operates from top down (World Bank, 1994). The dispensaries, health centers and small rural hospitals are intended to provide Primary Health Care (PHC) while the major hospitals are left to deal with referral cases. This organization has come about from the decentralization policies by many governments. Since, the majority of the population live in the rural areas, there is recognition that greater care should take place at the PHC level (Amondo-Lartson, 1994) where the impact of PHC would be expected to be significant.

The concept of health centers is therefore a necessary part of the health care system. It has been found that they have performed more effectively at less cost than hospitals in providing PHC (World Bank, 1994). Governments in developing countries are therefore frequently faced with the task of implementing a national PHC policy (Amondo-Lartson, 1994). Unfortunately, these countries have been slow to show commitment in encouraging Primary Health Care (PHC) the emphasis being on hospital-based programmes, which a large part of the population cannot access. The investment of resources in construction, equipping of hospitals and training of highly qualified medical staff deprives the Primary Health Care (PHC) system of adequate resources for its improvement (Amondo-Lartson, 1994).

Although the state is also under an obligation to provide a healthy environment to the prisoners (Reyes, 2001), it is apparent that prisons lack the basic amenities such as water

and proper sanitation leading to water borne diseases. Much of the expenditure on curative health care in the public sector would be better put in improving the environment in and out of prisons. The cost of remedial environmental hazards increases while communicable diseases abound (Mburu, 1983). The congestion in prisons leads to the spread of infectious diseases such as tuberculosis and pneumonia (IMLU, 2005). Cases abound of inmates succumbing to illnesses due to the negligence in providing care to inmates once they contract illnesses and disease (IMLU, 2005). Thus the interaction of remandees with outsiders such as prison and judicial staff, family visitors and lawyers increases their vulnerability to diseases and illnesses (Reyes, 2001) hence affecting the general well being of inmates.

In view of the fact that inmates suffer from infectious due to congestion and poor sanitation, there is need to emphasise the importance of PHC in providing health care to inmates as a cost- effective mechanism.

2.1.3. Structural Adjustment Programmes and sustainability of health care facilities

Since 1980, a wave of de-nationalisation has made a shift from state capitalism to a more pure market –regulated capitalism (Gakuru, 2002). This has meant that national economies are interlinked. It is also a multi-dimensional concept incorporating economic, culture and political dimensions (Gakuru, 2002). As a result of globalisation, the economic recession experienced by most countries in the 1980's saw the Bretton Woods Institutions sponsor a series of Structural Adjustment Programmes (SAPs) (Shauri, 2001). These were implemented in most developing countries. The SAPs resulted in the increasing privatisation of services and introduction of cost-sharing in the health sector (Shauri, 2001; World Bank, 1987, Collins *et al.*,1994; Mbatia, 1996).

Previously, health care was free and governments were reluctant to introduce user fees in most African countries (Geest, 1992). People felt that this was a service that had to be provided free by the governments (Korte *et al.*, 1992). The Bamako Initiative proposed to give up the idea of free medical care if the health system was to be maintained (Geest, 1992). The new cost-sharing policy under the SAPs required that users of public services pay user fees. The purpose of the user fees was to increase the government's financial capacity to provide good quality health care in the face of the increased cost of health

care (Republic of Kenya, Kenya National Development Plan, 1989). The assumption here was that cost-sharing fees would ensure resources were available and that health facilities were run efficiently.

Since socio-economic differentiation is considered to be both unethical and socially undesirable, there is need for some countries to enact legislation providing free access to medical care as a constitutional basic human right of all citizens (Njeru *et al*, 2004). While economic productivity is not directly dependent on health status, there can be no economic growth without good health (Mburu, 1983). The Kenya government policies therefore endeavour to promote the eradication of poverty through economic growth and access to minimum quality health care. This can be achieved by removing barriers arising out of social differentiation and concomitant stratification on the basis of gender, social class, knowledge and limited or no participation of the underprivileged in prioritization and provision of the national service infrastructure. It is appreciated that a healthy population is capable of actively participating in economic, social and political development and is thus a great asset to any country.

However, due to social and political reasons, governments tend to charge lower user fees in rural areas (Korte *et al*, 1992). In Kenya, outpatient fees were temporary suspended on 1st September 1990 (Shauri, 2001) as it had been observed that people stayed at home with their illnesses (Mbatia, 1996). Between 1992-1993, the District Health Management Boards (DHMBs) formed in May 1992 (Kenya Gazette, 1992) recommended low outpatient fees. This was designated as the acceptability phase (Shauri, 2001). Unfortunately, the fees were insufficient to improve the health facilities. According to Vogel, the budget that governments expect to collect from user fees is 0%-15% (Vogel, 1989). Considering that there is huge demand of health care services, this is very low to sustain a health system. The withdrawal of state subsidies through the Structural Adjustment Programmes (SAPs) has had a great impact on national social structures such as poverty, population and urbanization (Gakuru, 2002).

In comparison, Kenya compares unfavourably with other countries in terms of prerequisites for sustainability of a social health scheme due to a poor economy, high poverty levels and shortfalls in facilities and services (Njeru *et al*, 2004). Notably, Kenya has been ranked 143 in the Human Development Index (HDI) with sustainable

accessibility to affordable drugs put at 0.49% (WHO, 2004). Equity is therefore a critical factor in health care delivery (Chaligha, 2004). The realization of vision centred on equity is based on the principle of availability and universal access (Reyes, 2001). Allocative equity demands that resources should be shared amongst the various sections of the population.

The economic status of the people is therefore central to the issue of accessibility of health care facilities. If people are economically endowed, they will travel to access the health care facilities. In addition, they will also be able to purchase medical insurance to access private health facilities and pay user fees when required to do so in the public health facilities. The inadequacy of or lack of resources and mismanagement at the national level which cannot be sustained by lack of contribution from the population therefore impacts on the provision of health care in prisons and prisoners are often forgotten in this equation. (Reyes, 2001).

2.1.4 Complexity of International Trade Practises

Foreign debt has curtailed the growth of third world countries (Bradshaw et al, 1993). It is unlikely that developing countries will ever achieve the high human development indices (HDI) experienced by developed countries. As at 1993 developing countries owed about US\$ 1.3 trillion to financial institutions and the developed countries (Bradshaw *et al*, 1993). The impact of foreign debt has been widespread and caused untold poverty to millions in developing countries. Many people in developing countries have been marginalized, gone without food, shelter, education or access to health care.

This marginalisation has further been compounded by unfair international trade practices. It is apparent that developing countries today face the complex challenge of implementing various international agreements that were negotiated during the Uruguay round (Correa, 2000). This can be attributed to the overall structure of underdevelopment and attendant dependence on imported drugs and equipment (Alubo, 1990). In the process, these countries are becoming increasingly aware of the many far-reaching implications in their development, economies and societies inherent in some of these agreements (Correa, 2000). The implementation of the Agreement on Trade-related

Aspects of Intellectual property Rights (TRIPs) is thus emerging as a major concern for all developing countries.

Further, international trade relations and policies are critical in the way they impact on the budgetary allocations of the government. In dealing with issues relating to access to medicine, provisions and mechanisms in patent laws that may increase affordability of medicines including diagnostics, preventive and curative medicines are crucial. There is therefore a need to have an integrated approach to the deeply inter-related issues of national health policies, pharmaceutical policy and patent policy (Correa, 2000).

Health development and trends in health system in Africa are therefore beset by uncertainties of having capacity to overcome poverty and to provide universal access to essential health care (WHO, 2000). This has impacted negatively on the health of the people because it is the people in the lower classes who will feel financial constraints when illnesses strike (WHO, 2001). Indeed, health constitutes a strong entry point for poverty reduction and economic growth (WHO, 2003). This is because poverty deprives these people of knowledge and information services. Indeed as has been aptly stated by Gor Harlem Brundtland “people choose to adopt healthier behaviours when they receive accurate information from the authorities they trust and when they are supported through sensible laws, good health programmes and vigorous public debate” (WHO, 2002: 5).

Prisoners rely on a very small part of the overall government budget. In the event the resources are not adequate, they are more likely to feel the effect when they are struck by illnesses due to lack of essential medicines, well equipped health facilities and medical personnel. Prisoners are members of a larger society and since they do not leave in isolation, they suffer from illnesses which they would have received treatment were they not in confinement.

2.1.5 Disparities in health status

Consequently, wide disparities exist in the health status of African countries making the prospect of achieving even minimal adequacy of health and health services in Africa a distant goal (Hoare, 1987). Large gender disparities in basic human rights such as health are also linked to poverty and hinder development. Inequalities between males and females in access to schooling or adequate health care are more acute among the poor

than among those with higher incomes. Educated, healthy women are more able to engage in formal sector employment, earn higher incomes and enjoy greater returns to schooling than uneducated women who suffer from poor nutrition and health. Investment in human capital especially girls' and women's education and health raises productivity. The types of policies and strategies promote gender equality and foster more effective development is therefore a critical factor (King *et al*, 2001).

Hence, whereas new data shows that people in many countries live a longer healthier life than just two (2) decades ago, there was a reversal of human development since 1990 due to the ravages of the AIDS/HIV pandemic mostly in sub-Saharan Africa. In Uganda and Zimbabwe, life expectancy has reduced by more than 15% and 17% respectively (UNDP, 1999). There was a large disparity between regions. It was evident that the link between economic prosperity and human development was neither automatic nor obvious because two (2) countries with similar income per capita could have very different Human Development Indices (HDI) values and vice versa. This has been seen to be determined by policy measures countries take to enhance their people's well being (UNDP, 1999). Similarly, there is bound to be disparity in health status between male and female inmates depending on the amount of resources each category is able to access at any given time.

2.1.6 Health Care Reforms

Health care reforms have therefore been recognised as being a fundamental step in strengthening a country's health care system. These reforms may involve a number of strategies, policies and interventions designed to strengthen the health care system (Dmytraczenko *et al*, 2003). Thus the WHO reforms have shifted the focus of health systems away from curative to preventive and promotional pattern of health interventions (WHO, 2003).

The 1989-1993 Kenya Development Plan emphasized the government's commitment to developments in the health sector that were geared towards the attainment of "HFA by the Year 2000" (Republic of Kenya, Kenya National Development Plan, 1989). The government integrated an approach to the health system that involved such essential components such as health education, provision of proper nutrition, basic sanitary

facilities, maternal and child health including family planning and immunization against major infectious diseases amongst other measures.

WHO has therefore targeted vulnerable groups such as women, children and the handicapped in its policies (WHO, 2003). This has come from the realization that sick women are more likely to avoid or postpone seeking medical care because of gender-based constraints such as domestic responsibilities, cost of travel and treatment (King et al, 2001). More often than not, these women are given low priority due to their low social status. It is worthy of note that gender inequalities impose large costs on the health and well-being of the whole population. They lower prospects of reducing poverty and ensuring economic progress (King et al, 2001).

Prisoners are also a vulnerable group as they cannot fend for themselves. Although the government is endeavouring to reform the prisons, a lot still needs to be done as the reforms that have been undertaken have not targeted the provision of health care to inmates.

2.1.7. Spatial distribution and allocation of resources

Protection of the public health is one of the most pressing issues in developing countries (Correa, 2000). This can only be achieved if resources are spent to promote access to health care to sustain a healthy population. Towards this end, the WHO Abuja Declaration of 25th April 2000 requires that member countries spend at least 15% of the Gross Domestic Product (GDP) on health. Currently, Kenya only spends about 9% of its GDP on health (Njeru *et al*, 2004). In 1995, the total expenditure on health was 25% while in 2000, the same stood at 30% (WHO, 2004).

The differentials in health status in most African countries are due to the fact that access to personal health care tends to be highly unequal across administrative districts and between rural and urban areas. In Nigeria, for example, three-fourths of the country's public and private health facilities are located in urban areas, which contain only 30% of the total population (Alubo, 1990). In addition, major urban health facilities are served with the largest proportions of highly trained health personnel (Vogel, 1989). In patient spending in major hospitals is applied to hospital-based treatment as opposed to curative

or promotive Preventive Health Care (PHC) (World Bank, 1994). However, if the budget allocated for treating the sick whose quality of life remains unchanged then that expenditure is wasted (Mburu, 1983).

Like other developing countries, Kenya also invested heavily in highly trained medical personnel. In 1988, there were 13.75 doctors per 100,000 population and 18.00 per 100,000 population in 1994 (Republic of Kenya, 1994; Mbatia, 1999). There was 1 doctor on average for 500 people compared with one per 160,000 people in rural Turkana district showing the inequality of distribution of medical personnel. In addition, the IMR (per 1000 live births) , CDR (per 1000 population) and Life Expectancy at birth varied by province. In the period 1979-1989, IMR was highest in Western and Nyanza Provinces at 101.0 and 111.0 respectively and lowest in Nairobi and Central Provinces at 49.0 and 30.0 respectively (CBS, 1996). In the case of Ghana, although there were huge increases in terms of manpower and health facilities, in 1975 the government recognized that there was little or no impact on the health status of its people (Amondo-Lartson, 1994). In both cases of Kenya and Ghana, it is evident that even where there has been infusion of resources in developing countries, this did not and has not translated to better health status of the people.

Consequently, various studies have been conducted with a view to finding a lasting solution to the inequitable distribution of health care in Africa and other countries. In Kenya, a recent study suggested that strong efficiency and equity reasons supported the spread of medical insurance (Mwabu *et al*, 2002). The researchers, however, pointed out that in institutionalizing insurance in communities, it was important to ensure that vulnerable groups in the community were not excluded from medical schemes that they invested in.

Another study conducted in Nigeria showed that the few health care facilities could not meet the health needs of its people. It was suggested that better access would mainly involve the establishment of new public health care facilities (Mbanefoh *et al*, 2004). The same study also found that there were high transportation costs and the time spent in accessing health care facilities in the rural areas. It has been suggested in other studies that that when distances between facilities and providers is short, the use of facilities is highest (Gesami *et al*, 2004). Previous studies in Kenya have also confirmed that the high

costs and long distances limit health care services for many Kenyans. One such study showed that 40% of the poor did not seek medical care when they fell sick due to financial constraints while 2.5% did not do so due to the long distance of the health facilities from where they stayed (Njeru *et al*, 2004). The approach taken by the scholars in this school of thought is based on the assumption that people will seek medical attention in health facilities provided they offer quality services and the distances are short.

This is rather a simplistic view as there are other factors that appear to influence whether a person will attend a health facility or not. Studies have shown that even when facilities are near, the demand for health care has decreased. This has been attributed to other policy interventions. Like in most other countries in the developing world, the introduction of cost-sharing in 1989 in government facilities in Kenya showed a decline in utilization. The largest decline was in government dispensaries, which experienced a decline of 68.81%, 44.33% in government hospitals while the same stood at 12.29 % at the health centres. In Kirinyaga district, clinic attendance decreased by 40% (Wang'ombe, 1995). Mbatia (1996) observed that Kenyatta National Hospital remained virtually empty as people suffered at homes with their illnesses. It was evident that people were prepared to pay for services if they were of high quality (WHO, 1993).

The negative publicity and lack of acceptability for the strategy by the poor persisted (Shauri, 2001). Many people suffered because of mismanagement of funds. The resultant effect was that millions of the Kenyan people could no longer access health care as the health system had become inefficient. It was found that a large part of the population that lacked access to essential drugs was amongst the poorest socio-economic classes, which translates into 50% of the population being unable to access the essential drugs (WHO, 1998). Currently, 56 % of the Kenyan population lives below the poverty line and survive on less than \$1 per day (Njeru *et al*, 2004).

Notably, there was less reduction in the non-governmental health facilities as people perceived them as being able to offer higher quality of the health services. (Gesami *et al*, 2004). Prisons have therefore embraced non-governmental organizations to complement the health care that the state provides to the prisoners and inmates.

The efficient management of those resources is therefore critical (WHO, 2000). It is instructive to note that in Kenya, the health care situation has deteriorated because of misuse of funds through corruption and inefficiency, rapid population, brain drain of medical personnel in search of better remuneration in stable economies in other parts of the world states and rising costs of health care (Owino, 1999). In Nigeria and Ghana, whole departments in medical schools and hospitals were paralysed from the brain drain (Alubo, 1990). Hence, the implications for present and future medical care due to deterioration of medical services are obvious and cannot be underestimated..

From the arguments above, there is no doubt that inadequate or poor allocation of resources for provision of health care is one of the primary causes of poor health in developing countries. It can therefore be safely concluded that the fact that there has been an increase in manpower in the medical field generally has not translated to better health care provision to prisoners as few medical personnel are attached to prisons and are consequently unable to cope with the huge numbers of inmates.

2.1.8 Equity and Rights Approach to health

Undoubtedly, prisoners are sent to prison as punishment, and not for punishment. (IMLU, 2005). This often repeated statement is attributed to the British prison commissioner Paterson. It implies that the loss of an individual's right to liberty should not negatively affect his health. Certainly they have a right not to contract disease in prison because contracting any disease in prison is not part of a prisoner's sentence. He must receive the requisite interventions. Intervention can be broadly defined as "any health action- any promotive, preventive, curative, or rehabilitative activity where the primary intent is to improve health (WHO, 2002).

Rights of human dignity regarding the health of prisoners are well captured in Section 7 of the Prisons Act Cap 90 of the laws of Kenya which provides that "the officer in charge shall:-

- (e) ensure as far as practicable that the medical officer's instructions and recommendations in regard to any prisoner are carried out;
- (e) pay special attention to prisoners in hospital or undergoing punishment;

(f) upon any dangerous illness of any prisoner, give immediate notice thereof to the most easily accessible known relative of the prisoner” (Prisons Act)

This socio-economic differentiation is considered both unethical and socially undesirable. Thus the idea behind equity and socio-economic agenda built in the economic recovery programme by the Kenya government for the period 2003-2007 was aimed at reducing or narrowing gaps of inequality in all sectors by creating wealth and employment (Kenya, 2003). For instance, the health reform measures in the said strategy include enacting legislation to convert the current National Hospital Insurance Fund into a National Social Hospital Insurance Fund, rehabilitation of existing health facilities, creation of an endowment fund to cater for the vulnerable groups and overhauling the whole drug procurement procedures (Njeru *et al*, 2004). The health reforms have therefore shifted the focus of health systems from curative to preventive or promotional pattern of health interventions. It is expected that these health interventions will create opportunities for the poor to enter the labour market with increased capacities and result in higher productivity thus alleviating poverty.

Human rights instruments therefore call for prisoners to receive health care at least equivalent to that available for the outside population (Reyes, 2001). On the one hand, “equivalence” rather than “equity” has been called for because a prison is a closed institution with a custodial role that does not always allow for the same provision of care available outside (Reyes, 2001). The challenges faced by inmates in Kenya and other countries can be traced to the lack of resources by the governments in sustaining facilities that would adequately cater for the health needs of the whole population. Indeed it has been found that providing basic health care to prisoners has been difficult in countries where the overall health systems have collapsed or are chronically insufficient (Reyes, 2001).

The involvement of non-state actors to supplement government efforts to provide essential health services to prisoners has also been recognized by the government. The Fr Grol Foundation run by a formation of Catholic brothers known as the CMM Brothers is one institution that has been supplying medicines to inmates in the more than 90 prisons

in Kenya (Daily Nation 16th July 2005). Other key players are Justice and Peace under the Catholic Church and IMLU amongst other organizations.

2.2. Theoretical Framework

2.2.1 General Systems Theory

Baker has defined a system as a set of interacting components which are interrelated and interdependent and which function as a structured and bounded unit (Baker in Viney et al, 1986: 239). A system may also be defined as a set of things so related as to form a unit with recognizable inputs and outputs (Garret, 1973).

Social system and action system constituted the core of structural functionalism. Structural functionalists assume that social life is organized as social systems (Parsons, 1951). The interdependence of parts forms the structure of the system. The General Systems Theory presupposes that no system can work in isolation. Each system must interact with other systems and receive a feed back. A negative feedback weakens the system and is conceptualized as a threat. If one system fails, then the whole system collapses. The system is forced to adapt and adjust towards a state of homeostasis.

According to Luhmann human action becomes organized and structured into systems when several people become interrelated. The systems involve goals that involve growth, expansion and increased adaptation. Such systems receive feedback on their current actions in an environment and the extent to which these actions help realize those goals to facilitate adaptation and survival (Turner, 1991).

2.2.2 Rational Choice Theory

Theories of rational choice are guided by the assumption that people are rational and base their actions on what they perceive to be the most effective means of achieving their goals. In a world full of scarce resources, individuals have to constantly evaluate and weigh alternative means against alternative ends and choosing between them, hence the term rational choice. This approach can be used to understand how people chose to

access different types of health care services. In sociology, the best known examples of rational choice are those associated with social exchange theory.

Exchange theorists conceptualise social interaction as a choice that people make to participate in an exchange after they have examined the costs and the rewards of alternative courses of action and then choosing the best alternative. One of the propositions adopted by the rational theorists is that goods will generally be more expensive if they are supplied by a monopolist than if they are supplied by a number of firms in competition with each other. In the case of the government, which is a monopoly providing health services in remand homes and prisons, accessibility will be more out of reach of the inmates.

2.2.3 Theory of the Power Elite

Power has to do with whatever decisions men make about the arrangements under which they live. For C. Wright Mills, class struggle revolves around the graded hierarchy of modern bureaucracy. The elite are the ones who determine the duties of others who are beneath them. They command bureaucracies and give orders (Mills, 1970). C. Wright Mills suggested that although there is a clash of personalities among the elite, there is a reciprocal attraction among the fraternity. The psychological affinities ensure that their interests are well catered for (Marvine, 1979). Both Mills and David Reisman contend that power is shared among those whose interests coincide and divides along where interests diverge. For instance, politicians speak on issues that will earn them a re-election.

Liberal observers find the issue of public opinion and mass media crucial in exerting influence on the dependent and subordinate. Both Mills and Reisman point to an increasing impersonal manipulation rather than command or persuasion as the favoured form of power play. It was Mill's view that bureaucracies not only rest upon classes, they also organize the power struggle of classes.

2.3 Conceptual Framework

The General Systems theory can be used to understand the structures within which inmates access health care in prisons. If all the social systems are interacting and emitting

a positive feed back all the goals are likely to be achieved. Inmates interact with sub-systems such as the judiciary, prisons and health care facilities while in confinement. They enter these various systems as inputs, are processed and emerge as outputs. If any of these systems fail to interact in a coordinate manner, then an inmate cannot reach the homeostasis state, that of attaining good health. The health system must therefore work in synergy with other systems such as the social, cultural, economic and political systems. If they do not do so, there is a threat. Hence, the overall system design has to do with policy formulation at the broadest level.

The state is the monopoly in providing inmates with health care while they are in confinement. Rational choice approach can be used to understand how people chose to access different types of health care services. In prisons, the resources are scarce. If there is no homogeneity in the various systems , it is expected that the inmates would have to weigh and evaluate their best options to enable them access health care. Consequently an inmate may make a rational choice to bribe as an alternative to ensure that he achieves the end result of receiving the basic form of treatment. Another may opt to give up on the treatment being offered and purchase drugs from outside the prisons.

It is important to point out that inmates are expected to conform to the power exercised by the prison warders. The bureaucracies ensure that the prisoners conform to the orders given by the prison warders. They are subjugated and more often than not the majority of them cannot make rational choices as they have to rely on external social systems such as family or community outsiders for resources to help them meet their health needs.

Until the recent prison reforms, inmates had no instruments of rational exertion of public will. This is because they did not have access to electronic and print media and could not contribute to the political debates or influence public opinion. Legislators who seek votes for re-election to parliament have therefore not seen it necessary to fight for their rights as they have nothing to gain from the inmates. The crucial notion is that one person in the exchange is dependent on the other for services, and values those services more than the other person values anything he can offer.

The general trend is that rarely do persons in the higher socio-economic classes end up in jail for their crimes. The theory of the power elite is useful here as the individuals in

those positions protect one another's interests. Indeed, prisons are generally seen as places for the lower socio-economic classes with people who have nothing to offer to the society. The inmates continue being in a state of poverty. In this regard, the elite do not share the same interests with such persons and consequently at the policy making level, the formulation of policies that would safeguard the inmates' interests is not prioritized.

3.1 Research Design

This chapter addresses itself to the research design used in the study. A research design is “ the plan, structure and strategy of investigation conceived so as to obtain answers to research questions and to control variance (Kerlinger, 1964:275). According to Singleton, research involves the planning, execution and interpretation of scientific observation (Singleton *et al*, 1988). Research design guides the research in collecting, analyzing and interpreting observed facts. Thus the key elements and considerations in the overall plan are what are referred to as research design.

Given the nature and scope of this research, qualitative and quantitative research methods were used in this study. The overall design was a study of Lang’ata Women’s prison and Nairobi Remand/Allocation prison. Experiences are best drawn from findings involving both sexes. The study thus attempted to compare the differences in the experiences female and male inmates came across in their effort to access of health care in the 2 prisons. Research applied survey research whereby a cross-sectional study was carried out.

3.2. Sampling procedures

“Sampling is the process of selecting a subset of cases so as to draw conclusions about the entire set” (Singleton *et al*, 1988: 163). The procedure for selecting a sample is called a sampling design. Sampling design is said to be “ part of a research plan which indicates how many cases of the study are to be collected” (Singleton *et al*, 1988: 137). The major distinction among designs is between probability and non-probability sampling. “Probability sampling is based on the process of random selection, which gives each unit of observation an equal chance of being included in the sample” Singleton *et al*, 1988: 163). Holding a sample constant, one will be assured of greater precision with a stratified sample. In this way, the sampling units were expected to benefit and add maximum value to the study.

There are about 93 penal institutions in each of the eight provinces in Kenya, two Borstal institutions and one Youth Corrective Training Centre. In Nairobi, which is the area of this study, there are 5 prisons, 2 short sentence institutions and 1 youth corrective training centre. However, it would require a lot of resources in terms of finances and time to cover all the institutions.

Nairobi Remand/Allocation Prison and Lang'ata Women's Prison in Nairobi were purposively selected. Being situated in the capital city of Kenya, the population in the said prisons is composed of persons from all ethnic and socio-economic classes. Hence, they are a cultural microcosm of Kenya's population. The two prisons were also purposively chosen due to limited resources to conduct the research in other areas. The prison headquarters are located in Nairobi, which made it easier to access information at short notice. In addition, Nairobi has the largest concentration of population including activities such as crime. It was therefore a good mitigation plan as the activities are likely to be replicated in the rest of the country. Consequently, the findings are likely to have greater impact on policy formulation.

3.3 Sample selection

It would not have been possible to interview all inmates individually due to the large number of inmates in prisons in Kenya. Data was collected from a cross-section of respondents to represent the larger prison population in Kenya. Multi-stage cluster sampling of the prison institutions followed by convenience or haphazard of the respondents were identified as the most efficient sampling techniques and were thus used. The first stage was to purposively select the respondents. These comprised of male and female inmates from the 2 prisons. The second stage was to purposively select inmates who were awaiting trial and those who had been convicted of their offences. Thereafter 1 respondent was purposively selected from each of the 2 prisons after being identified by the officer in charge and in turn requested to purposively select five respondents in each category of person who had received no education and those who had attained primary, secondary, college and university education levels. These purposively selected respondents were used as units of observation.

Due to time and cost constraints, a sample of 60 respondents was chosen. These included 30 male and 30 female inmates. Males and females aged between 18-40 years awaiting trial for offences and those convicted were included. The study, however, excluded male and female inmates who did not consent to be part of the study. In addition 1 female inmate who had been purposively selected declined to complete her questionnaire. In the end, the researcher collected data from 29 female respondents. The sample of the units of observations was representative of the entire population of male and female persons in custody in the two prisons were selected.

3.4 Target Population

This study targeted adult between the ages of 18-40 years, from both sexes, various ethnic groups of Kenya and socio-economic classes. This was, however, limited to those who were in confinement the Nairobi Remand/Allocation and Lang'ata Women's Prisons.

3.5 Unit of observation

Observation unit or unit of data collection is an element or aggregation of elements from which information is collected (Singleton *et al*, 1988). In a majority of the cases, although the unit of analysis and unit of observation are often similar, this is not always the case. Hence, the unit of observation is the source of the data. The units of observation in this study were the adult male and female inmates and the key informants.

3.6 Unit of Analysis

The entities under study are referred to as units of analysis. Units of analysis are defined as "the entity around which a researcher seeks to make generalizations" (Singleton *et al*, 1988: 97). It has also been defined as "that which a study attempts to understand" (Barbie, 1995: 193). Hence, it refers to some attribute that must be the subject of the study. The unit is simply what or who is to be described or analysed. In this case the unit of analysis was the access of health care by inmates at the 2 prisons.

3.7 Types and sources of data

Both primary and secondary sources of data were used to arrive at the findings. Primary data was collected from the inmates, judiciary, administrative prison officials, prison welfare officers, non-governmental organization and medical personnel from the Ministry of Health. These key informants were purposively selected due to their expertise in the areas of the research that was being undertaken.

In this regard, the researcher selected a police prosecutor, a senior administration officer from the judiciary, a priest working for a non-governmental organization, a prison, a social welfare officer, a senior prison official, a registered nurse and public health officer as key informants.

Secondary data was obtained from local and international published and unpublished works, journals from public and private organisations, periodicals, books and the internet. This was to ensure that relevant information was obtained. It was not possible to obtain secondary data from prison records due to security reasons.

3.8 Methods and tools of Data collection

Emphasis was put in obtaining qualitative data and to a lesser extent data that was quantitative in nature. The research utilized interviews and direct observation as data collection methods. Direct observation consists of systematically observing a phenomenon, event, process and physical object in its natural setting. This mainly involved watching and noting down the presence of or absence of any factors that could affect access of health care to inmates. The researcher observed the conditions of seeking treatment, cleanliness of the surrounding environment and type of food given. The direct observation provided qualitative data. The observation check list is attached as Appendix C. Other additional data collection tools were literature review, field notes, case studies and theoretical framework.

The principal tool that was adopted was the interview schedule. The adopted interview schedule contained structured questionnaires with open and ended questions. They contained definite pre-planned questions having three sections inter alia A, B and C.

Section A dealt with demographic characteristics of the inmates and their responses to how they accessed health care in prisons. Section B sought to know their perceptions of the adequacy of the health care delivery in prisons. Section C invited the respondents' recommendations on the long term strategies for efficient health care delivery in prisons.

The key informant guide is a tool used to obtain data from unstructured interviews. "Non-directed (unstructured) interviews entail objective wide engaging discussions creating spontaneity in the course of the interview" Singleton *et al*, 1988: 123. Hence, the interview guide was selected so as to gain in depth information. The key informants generated individual opinions and perceptions openly and freely.

Summary

Method	Tool	Source of data
1. Direct observation	Observation checklist	Primary
2. Oral Interview	Interview schedule (questionnaire) Interview guide	Secondary

3.9 Data Analysis

Data analysis is the interpretation of the collected raw data into useful information. This concerns methods and ideas for organising and describing data using graphs, numerical summaries and more elaborate mathematical descriptions. Content analysis was taken to reduce the data to a more manageable set of observations. Raw data was cleared, coded based on the response categories that emerged from the collected data. With the aid of a computer, quantitative data received from the interviews was analysed to assist presentation and collation of research findings using SPSS. All the data was first systematically arranged and coded using the SPSS programme.

Descriptive statistics have been used to present and interpret the data. Tables and figures have been used to capture the required information. Throughout the research, efforts were made to provide answers to the research questions. Analysis of the research findings was based on the conceptual framework of the study.

Qualitative data derived from structured, semi-structured interviews and field notes was evaluated and analysed to determine the adequacy of the information and the credibility,

usefulness in carrying out the exploratory study. The data was categorised into themes to be able to discern the properties, dimensions and trends.

4.0. Background Information

The findings of collected data are presented and analysed in this chapter. The findings are based on research objectives and reflected in five sections. These are demographic features of respondents, health care delivery in prisons, factors affecting access of health care and attitudes towards the health care delivery.

The data was then subjected to mathematical calculations for purposes of summarizing and presenting the same as percentages, tables and bar charts. The information was then tabulated, cleared and edited. Cross-tabulation on gender lines was carried out. The data has been analysed using descriptive statistics.

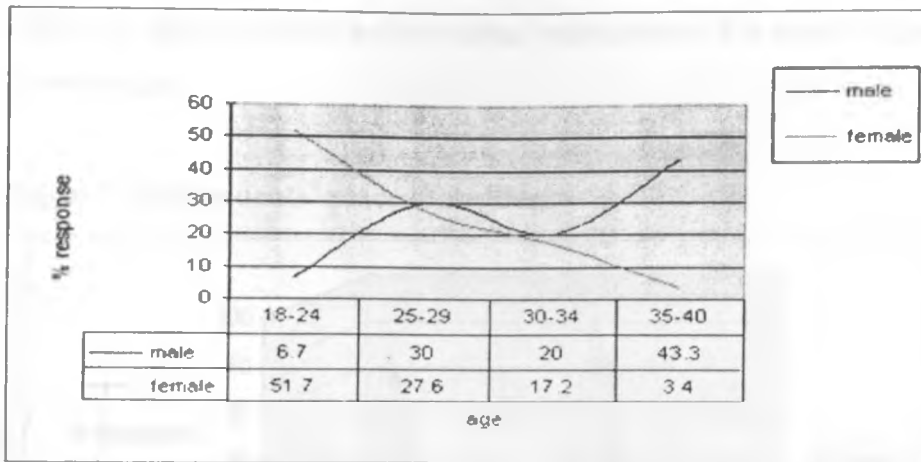
4.1. Demographic features of the respondents

4.1.1 Age of inmates

The data collected shows that 51.7% of the female respondents were in the age group of 18-24 years. In that age group, the male respondents accounted for 6.7%. The rate of offending between the ages of 25-29 was almost equal. The male respondents were 30% while the female respondents were 27.8%. Notably the number of respondents in the 30-34 age group showed a decline for both male and female respondents. The male and female respondents accounted for 20% and 17.2% respectively. However, the number of offending male respondents rose to 43.3% in the age group 35-40. The female respondents accounted for the least number (3.4%) of offenders in this particular age group.

The rate of high crime in respect of female respondents in the 18-24 age group could be attributed to the fact that they were mainly single and may have had to cater for their own needs and those of their families. On the other hand, the incidence of crime in the 35-40 age group could have been as a result of the fact that males at this age have more family responsibilities and have to look for means to look after the needs of their families. This assumption has been deduced from the age group, marital status, gender tabulation shown in Table 1.

Figure 1: Age of inmates



4.1.2 Marital status

It is clear from Table 1 below that the age group 18-24 which accounted for the greatest number of the female respondents who had committed offences also had the highest number of single female respondents (72.4%). On the other hand, the age group of 34-40, which had the greatest number of offending male respondents had the higher number of married male respondents (70%). The divorced group accounted for 6.7% and 6.9% for male and female respondents respectively.

Table 1: Marital status of inmates

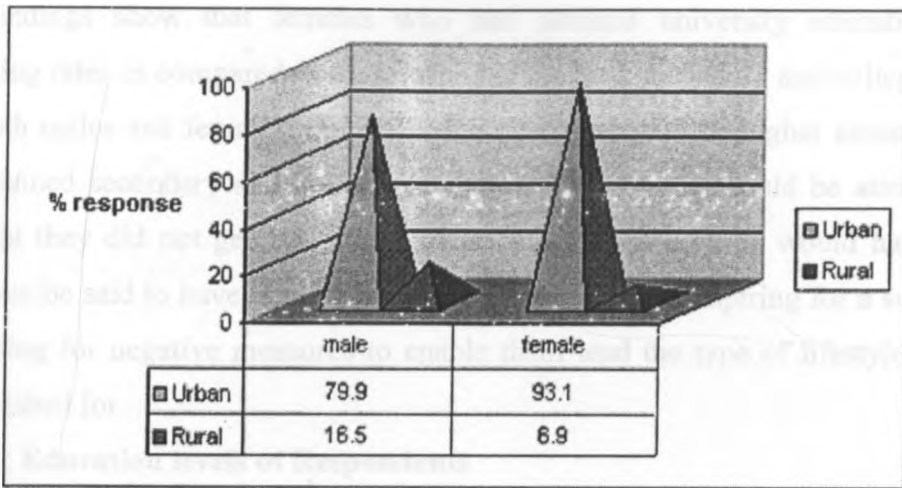
Count			Marital Status			Total
Respondent's Gender			Married	Divorced	Single	
Male	Age Group	18-25	1		1	2
		25-30	4		5	9
		30-35	3	2	1	6
		35-40	13			13
	Total		21	2	7	30
Female	Age Group	18-25	3	1	11	15
		25-30	2		6	8
		30-35	1	1	3	5
		35-40			1	1
	Total		6	2	21	29

4.1.3. Place of residence

There were 79.9% male respondents who resided in urban areas. Male respondents from the rural areas accounted for 16.5%. Amongst the female respondents, 93.1 were from the urban and 6.9 % were from the rural areas respectively. It emerged

from the data collected that male and female respondents from rural areas had less offending rates compared to their urban counterparts. The data is captured in figure 2 here below.

Figure 2: Respondents' place of residence



4.1.4. Sex and religious affiliation

It is appears from the data collected that religion was a factor when considering the offending rate. The lowest offending rate was amongst the Muslims (6.7%). Amongst the Christians, 90% were male and 75.9% were female. Only 1 male respondent declined to declare which religion he professed. The low offending rate amongst the Muslims could be attributed to their cultural and religious norms.

Table 2: Respondent's religious affiliation

Count		Religion			Total
		Christian	Muslim	unanswered	
Respondent's Gender	Male	27	2	1	30
	Female	22	7		29
Total		49	9	1	59

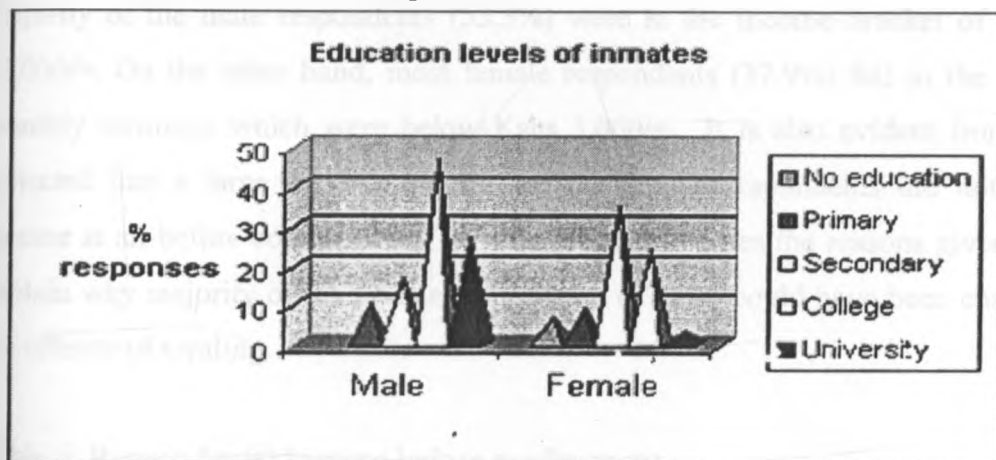
4.1.5. Education levels

The minimum education attained by male respondents was primary level (10%). In contrast 6.9% of the female respondents had not received any formal education. There were more female respondents (31%) who had attained secondary education compared to male respondents (16.7%). On the other hand, there were more male respondents

(46.7%) who had gone up to secondary level. This was compared to 34.5% of the female respondents. The percentage of female respondents who had attained university level education stood at 3.4%. This was very minimal when compared to 26.7% for the male respondents.

The findings show that females who had attained university education had less offending rates as compared to those who had attained secondary and college education. For both males and females, the offending rate appears to be higher among those who had attained secondary and college education. This finding could be attributed to the fact that they did not get financially rewarding careers as they would have expected. They can be said to have been in a state of anomie, that is, aspiring for a successful life but opting for negative measures to enable them lead the type of lifestyle they would have wished for.

Figure 3: Education levels of Respondents



4.1.6 Income

It is clear from Table 3 below that 65.8% of the inmates had been charged with the economic offences. These are economic offences intended to raise a person's standard of living. These included stealing (42.4%), handling stolen property (3.4%) and drug trafficking (20.3%).

Table 3: Offences committed by Respondents

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Murder	9	15.3	15.3	15.3
unanswered	3	5.1	5.1	20.3
Stealing by servant	25	42.4	42.4	62.7
Handling stolen property	2	3.4	3.4	66.1
Not charged yet	1	1.7	1.7	67.8
Touting	1	1.7	1.7	69.5
Being in the country illegally	3	5.1	5.1	74.6
Drug Trafficking	12	20.3	20.3	94.9
Causing greivous bodily harm	1	1.7	1.7	96.6
Chang'aa Brewery	1	1.7	1.7	98.3
Robbery with Violence	1	1.7	1.7	100.0
Total	59	100.0	100.0	

4.1.6: Income

Majority of the male respondents (53.3%) were in the income bracket of over Kshs 12,000/=. On the other hand, most female respondents (37.9%) fell in the bracket of monthly earnings, which were below Kshs 3,000/=. It is also evident from the data collected that a large number (20.7%) of the female respondents did not earn any income at all before confinement. This data indeed fortifies the reasons given above to explain why majority of the female respondents (27.6%) could have been charged with the offence of stealing.

Table 5: Respondents' Income before confinement

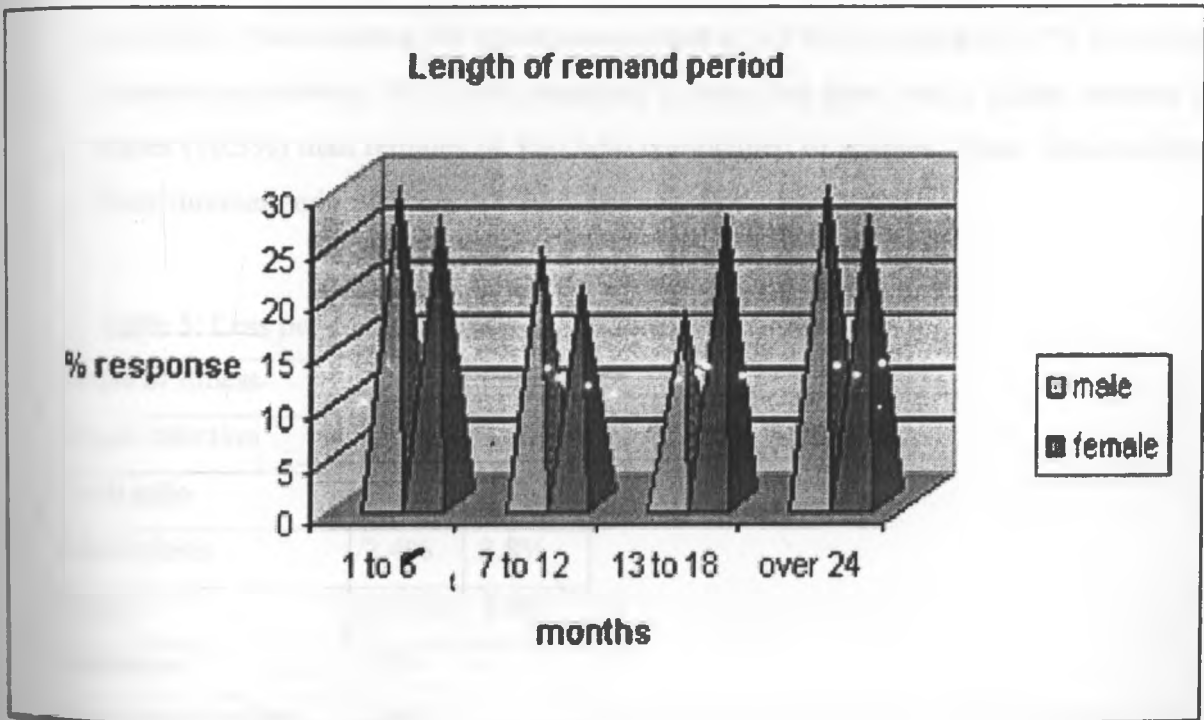
Monthly income before confinement in Kenya Shillings	Respondents Gender		Total
	Male	Female	
Below 3000	13.3%	37.9%	18.6%
3,100 to 6,000	16.7%	3.4%	8.5%
6,100 to 9,000	13.3%	13.8%	15.3%
9,100 to 12,000	53.3%	3.4%	8.5%
over 12,000	3.3%	17.2%	35.6%
N/A	-	20.7%	11.9%
Irregular		3.4%	1.7%

4.1.7. Duration of remand

There were 29.4% of the males and 24.7% of the female respondents in remand at the prisons for the period of 1-6 months. Among those who had been in custody for 7-12 months, 23.5% were male and 20% were female. On the other hand, there were 26.7% of the male remandees and 17.6% of the female remandees in remand for a period between 13-18 months. Those who had stayed in custody for over 24 months accounted for 29.4% (male) and 26.7% (female) respondents.

There does not appear to be any preferential treatment given to any one of the sexes as far as being in custody is concerned. The data shows that the remandees who had stayed in custody for any one given time was not significantly different for both male and female respondents

Figure 4: Duration of demand period



4.2 Main Findings

The first specific objective was to establish the prevalence and nature of diseases and illnesses affecting inmates. Inmates complained of suffering from a myriad of

illnesses. There were problems that were common to both sexes while some were specific to them. Data collected showed that 10 female respondents complained that they suffered from tumors, cancer, goiter, arthritis, fibroids, stress, depression, heartburn, leg pains and urine retention problems. Each of these conditions accounted for 4.3% of the responses. Out of the respondents who were interviewed, 13% of the female inmates complained of headaches while no male inmate complained of the same. Amongst the male inmates, the data collected shows that there were certain diseases that were restricted to their sex. These were allergies, meningitis and herpes, which accounted for 3.4% of the responses for each condition.

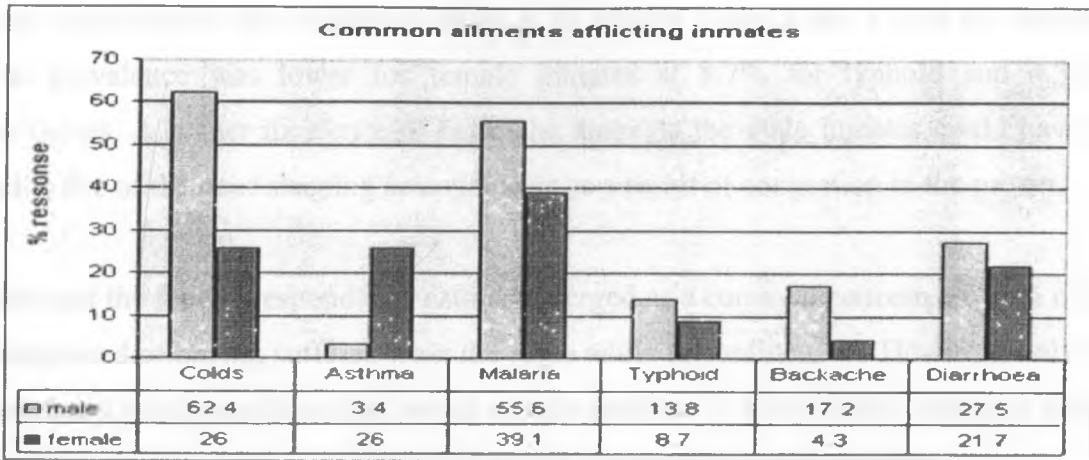
Other less common problems affecting both male and female inmates included fungal infection standing at 3.4% and 3.8% for male and female inmates respectively. On the other hand, 8.7% (female) and 6.9% (male) of the respondents complained of toothache. The response for tuberculosis stood at 3.4% for male and 3.8% for female inmates respectively. It is also important to note that there was a higher number of males (10.3%) than females (4.3%) who complained of scabies. These illnesses have been summarized in the Table 5 here below.

Table 5: Less prevalent illnesses

Nature of illness	Male	Female
Fungal infection	3.4%	3.8%
Tooth ache	8.7%	6.9%
Tuberculosis	3.4%	3.8%
Scabies	10.3%	4.3%
Headaches	13%	-
Tumor and Cancer	8.6%	-
Goitre	4.3%	-
Arthritis and leg pains	8.6%	-
Fibroids	4.3%	-
Depression and stress	8.6%	-
Heartburn	4.3%	-
Urinary retention	4.3%	-

However, there were those ailments whose prevalence appeared to be high. The most common of these were colds and malaria. Figure 5 below captures the various ailments that both the female and male inmates suffered from while they were in confinement.

Figure 5: Common ailments afflicting inmates



The study showed that 62.4% of the male respondents had suffered from colds and related complications such as flu, coughing, sore throat tonsils and influenza. The prevalence for the same conditions was lower for females. Indeed, only 26% of the female inmates complained of similar problems. It appears that the congestion in the prison for males was conducive to the spread of infectious diseases such as colds. At the time of the research, the head count at the Nairobi Remand/Allocation Prison was over 5,000 while the premises could only accommodate about 400 persons. The head count at the Lang'ata Women Prison was about 600 as opposed to 100 persons.

A further 55.6% of the males had suffered from malaria. On the other hand, only 39.1% of the female respondents complained of having suffered from malaria. A higher incidence of Malaria amongst the male inmates could be attributed to the presence of stagnant water in the prison. The researcher's observation was that the draining of the soup from the food into the trenches and running water from the bathing area provided a good breeding ground for mosquitoes.

Diarrhoea was another major concern for the inmates. Out of the respondents who were interviewed, 27.5% (male) and 21.7% (female) reported that they had suffered from diarrhoea. Diarrhoea in both male and female prisons could be attributed to the food

preparation. Majority of the inmates complained about the poor diet and its preparation, which they said led to their poor health and stomach problems. It was the view of the voluntary health worker that the prisons lack water resulting to poor sanitary conditions.

Typhoid and backaches were also a major problem area for male inmates. Amongst the male respondents, the percentage stood at 13.8% for typhoid and 17.2% for backaches. The prevalence was lower for female inmates at 8.7% for typhoid and 4.3% for backaches. A higher incidence of backache amongst the male inmates could have been indicative of the poor sleeping arrangements as a result of congestion in the prison.

Amongst the female respondents, asthma emerged as a common concern as 26 % of them complained of having suffered from the same while in confinement. However, only 3.4% said that it was a condition that posed a major problem to their health. Amongst the male respondents, only 3.4% complained of having suffered from the condition.

There was a lower incidence of fungal infection and skin rashes amongst both male and female respondents. This could be attributed to the efforts by the public health office in the male prison in educating inmates about cleanliness and proper hygiene. The prison utilized the labour from the inmates to maintain cleanliness and in pest control. Although inmates washed their own clothes, it was also the responsibility of the Public Health Office to take the clothing for disinfection. There was also a lot of peer pressure from other inmates to the sick inmates to take treatment seriously to avoid the spread of contagious diseases and illnesses. This was done in collaboration with the welfare officer. The Social welfare office normally liaised with the inmates who were in charge of the wards to ensure that sick inmates took the prescribed medication, bathed and washed their clothes. At the women's prison, the prison wardress was charged with the duty of ensuring the inmates' cleanliness thus reducing the incidences of skin rashes.

4.3 Health Care delivery in prisons

The second specific objective was to study how health care is delivered in prisons. The data collected indicates that there exists an elaborate system within which inmates access treatment while they are in prison or custody. There are various players in the different systems in the prisons, courts and hospitals that they attend to receive the medical

4.3.2. Nairobi Remand/Allocation

The prison is under the command of the Officer in charge. There are 2 prison dispensaries, which are open 24 hours a day. There is also 1 laboratory to carry out the necessary tests. The Voluntary Counselling Centre (VCT) Centre, which is outside the prison, serves both the inmates in both the Short-term prison and Nairobi Remand/Allocation. A clinical officer and a nurse man the VCT Centre. They are assisted by a public health officer. The Public Health Officer is also mandated to give male inmates public health education on Primary Health Care (PHC), cleanliness and sanitation. Short-term prisoners attend the VCT, which also serves the public residing in the environs of the prison such as Mukuru Kaiyaba. All other inmates attend the prison dispensary, which is inside the prison.

At the prison dispensary, there are 2 clinical officers assisted by several nurses. The officer in charge of the station is given the duty rooster of the medical personnel manning the clinics on any particular day. There are 2 nurses on call every night in case of emergencies.

Prison officers appoint particular inmates to be in charge of the different wards. These inmates are required to report cases of sick inmates to the duty officer. It then becomes the responsibility of the duty officer to organize for transport if such an inmate has been referred to Kenyatta National, Mbagathi or Mathari Mental hospitals. This is a task the duty officer is charged with 24 hours a day. The inmates are taken to the health facilities inside prison and within the prison premises under heavy escort to prevent them from escaping from prison. This security detail comprises a uniformed officer and 2 assistants.

After an inmate is treated, the card is left at the dispensary for purposes of monitoring appointments and reviews, if any. The prisoners are given drugs to take to their wards. Inmates in charge of the wards, the duty officers and the other inmates monitor the taking of medication by sick inmates. This is to ensure that infectious diseases are not transmitted to the other inmates and warders. In the prison history at the Nairobi Area/Remand Allocation, there has not been a single incident of a male inmate committing suicide. Hence, unlike the female inmates, the male inmates are allowed to take the dispensed medicines to their wards.

An inmate is taken to a private hospital only if a doctor who has attended to him in a public health facility issues him with a referral letter. As in the case of Lang'ata Women's Prison, private hospitals are generally not utilized due to the large number of prison warders who would be required to accompany an inmate who has been referred there.

On its part, the social welfare office addresses social issues affecting inmates and members of staff by offering socio-psycho (therapy) counselling. It is the responsibility of the social worker to counsel convicts to ensure that once they serve sentences for offences such as murder, rape, robbery and indecent assault, they are easily re-integrated into the society so as not to suffer from recidivism.

A non-governmental organization supplements the government's efforts to supply drugs to prisons. The organization brings drugs to the inmates upon their request. Supply of the drugs is subject to availability at Mission Essential Drugs Supplies (MEDS). However, drugs, which were likely to induce dependence on the part of the inmates such as sedatives or those that can be used to commit suicide are not given directly to the inmates. If such drugs have been prescribed but are not available at the prison health pharmacy, they are channeled through the dispensary for onward dispensation to the concerned inmates. The organization also brings inmates spectacles on the basis of prescriptions given at the public hospitals or prison dispensary.

In the event an inmate dies in prison, there is an elaborate system in place to establish how the death occurred. This is particularly pertinent if negligence is found to have been the cause of such death. Disciplinary action is the consequence where the negligence of an official is proven. For instance, if an inmate dies in a particular cell or block, the warden in charge is answerable. If the inmate dies at the dispensary, the medical personnel manning the dispensary at that particular time are required to give a written report on what transpired. If an inmate had been referred to a hospital, the duty officer who was to arrange the transport is answerable.

Where it is clear that the health of an inmate is in great danger, the judicial officer exercises her discretion to allocate early hearing dates for the determination of the cases.

To ensure a holistic approach involving the convicts, she visits the prisons every 3 months. This is mainly to cater for those inmates who have been charged with non-bailable offences or have been convicted. The monitoring of compliance of court orders ensures that inmates receive medical attention. This is particularly important in the case of inmates suffering from mental problems. This monitoring is achieved through frequent mentions of the matters in court to obtain feed back from the inmates especially those who are awaiting trial. Issuance of production orders to compel prison authorities to produce sick remandees in court is also frequently utilized. Inmates are also at liberty to write directly to her highlighting their health problems.

It emerged that although the overall procedures were similar, each prison had its own peculiar challenges in providing health care to its inmates. A summary has been shown in Table 6 here below

Table 6: Delivery of services

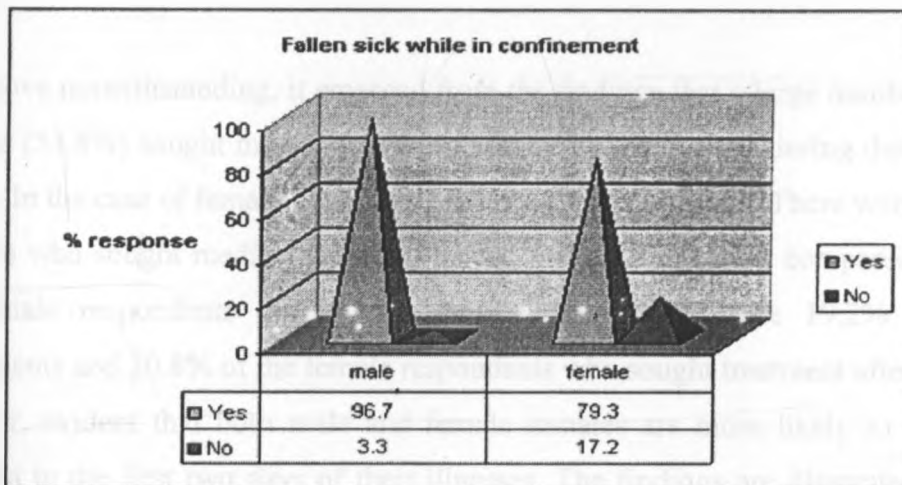
Services provided	Lang'ata Women's Prison	Nairobi Area/Remand Allocation
Chain of command in reporting illnesses	Sick inmate reports to an inmate identified by the prison authorities as in charge of ward	Sick inmate reports to an inmate identified by the prison authorities as in charge of ward
	Incharge of ward reports to the officer on duty	Incharge of ward reports to the officer on duty
	Officer in charge refers sick inmate to the nurse-in-charge as the clinical officer is rarely present.	Officer in charge refers sick inmate to the clinical officer.
Medical personnel attached to prison	Clinical officer assisted by the Nurse in charge and 10 nurses. Attached under Nairobi Provincial Officer of Health under Ministry of Health	Clinical officer assisted by several nurses and Public Health Officer. Attached under Nairobi Provincial Officer of Health under Ministry of Health
Security measures while dispensation of drugs	Inmates consume the drugs at the prison clinic to prevent the same from being used for abortion, suicide or poisoning other inmates. The nurse-in-charge monitors the taking of drugs.	Inmates take drugs to their wards as no case has been reported on suicide or poisoning other inmates. Compliance is monitored by the in charge of the ward, duty officer and other inmates.
Monitoring and review of progress	Through Direct Observation treatment.	Through perusal of cards left at the clinic.
Referral to more equipped hospitals	Referred to Kenyatta National Hospital and Mbagathi District Hospitals by the nurse-in-charge	Referred to Kenyatta National Hospital and Mbagathi District Hospitals by the nurse-in-charge
Number of prison dispensaries	1 prison dispensary open 24 hours and a Voluntary Counselling Centre open during the day.	2 prison dispensaries open 24 hours and a Voluntary Counselling Centre opened during the day.
External assistance	None. However, presiding magistrate visits the prison.	Non-governmental organizations. Presiding magistrate visits prison.

4.4 Factors affecting access to health care by inmates

The third objective of this study was to identify the factors that affect inmates when accessing health care in prisons. The number of those who sought treatment is an important aspect when looking at the factors that affect access of health care to inmates. This is because it gave a clear picture as to whether the health care facilities were able to cope with the provision of health care to inmates.

It is evident from Figure 6 below that there was a high number of respondents who had fallen sick while in confinement. Out of these, there were high numbers for both male (96.7%) and female (79.3%). Amongst the male respondents only 3.3% stated that they had not fallen sick while the same stood at 17.2% for the female respondents.

Figure 6: Prevalence of falling sick while in confinement

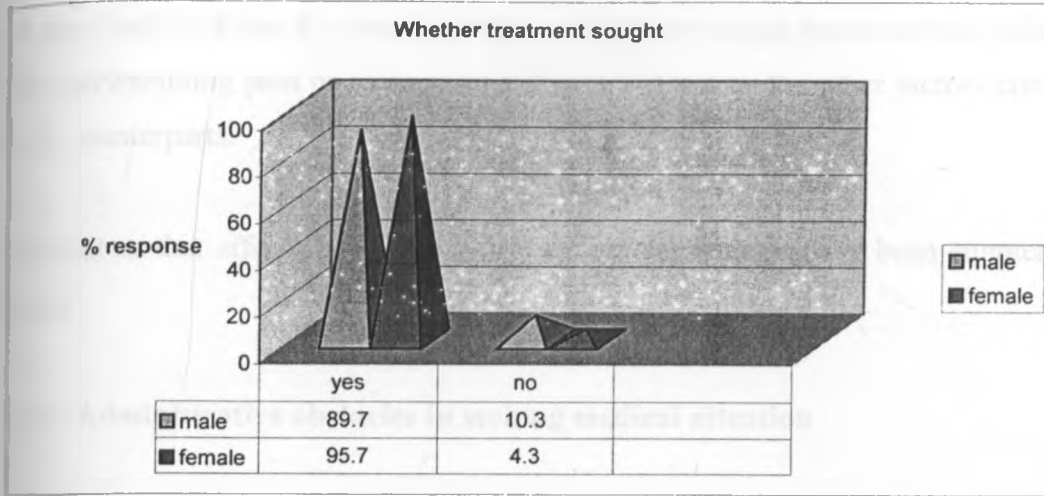


Out of those 89.7% and 95.7% of the male and female inmates respectively sought medical attention. The data clearly shows that women were more likely to seek medical attention when they fell sick while in confinement as compared to their male counterparts.

The high incidence of seeking medical attention could also be attributed to the fact that majority of the female inmates were from urban areas. The data shows that 93.1% of the female inmates were from urban areas and 6.9% were from the rural areas. Amongst the male inmates, 79.9% were from urban areas while 16.5% were from the rural areas.

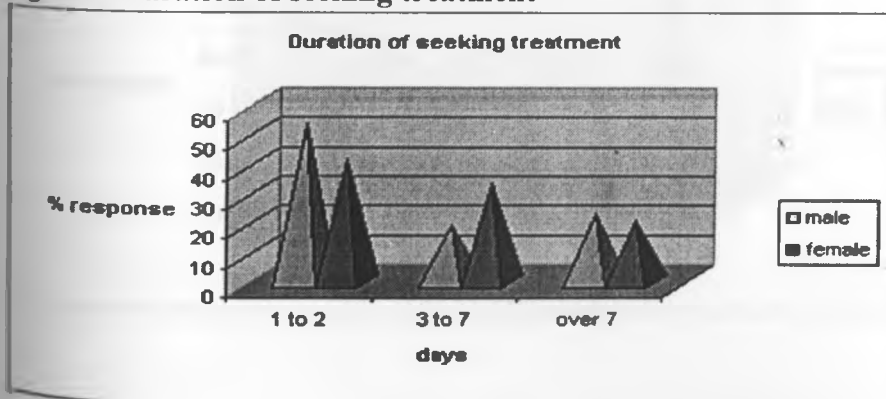
Generally, people from urban areas have more and better health facilities and are more likely to seek medical attention as compared to their rural counterparts. This trend is also evident in prisons and could explain why more women managed to demand for treatment in referral hospitals such as Kenyatta National Hospital, Nairobi.

Figure 7: Seeking of treatment



The above notwithstanding, it emerged from the findings that a large number of the male inmates (53.8%) sought medical attention within the first 2 days during their most recent illness. In the case of female, it was 41.7% for the same duration. There were fewer males (19.2%) who sought medical treatment in the period of 3-7 days compared to 33.3% of the female respondents during the same period. There were 19.2% of the male respondents and 20.8% of the female respondents who sought treatment after 7 days. It is, however, evident that both male and female inmates are more likely to seek medical attention in the first two days of their illnesses. The findings are illustrated in Figure 8 below.

Figure 8: Duration of seeking treatment



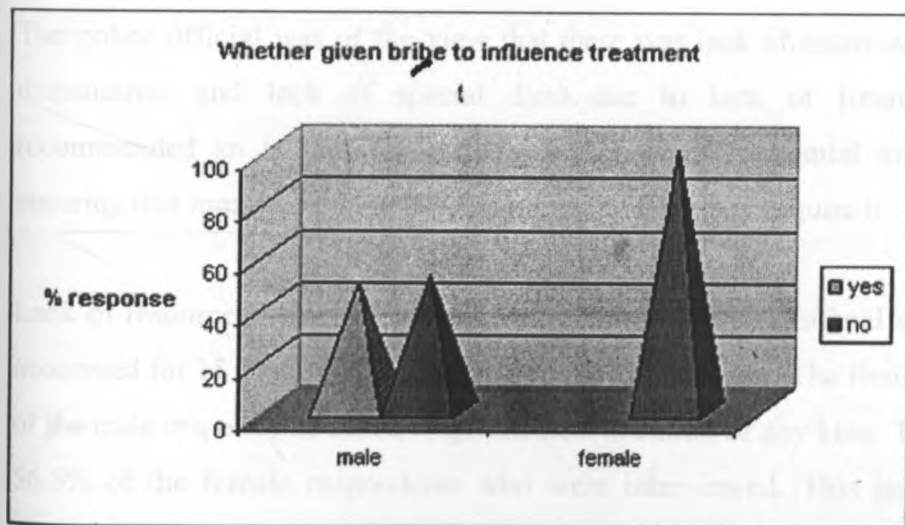
It is important to point out that even after falling sick, various factors came into play before an inmate could decide to seek medical attention. It is instructive to note, however, that although the male inmates took a shorter period to seek medical attention, 65.5% of the male inmates did not receive medical attention even after attending the medical facility compared to 56.5% of the female inmates. Amongst the female respondents, 16.7% of them indicated that the duration within which they sought treatment was influenced by the overwhelming pain or feelings of sickness and not by the other factors cited by their male counterparts.

The factors that affect access of health care among inmates have been enumerated here below.

4.4.1. Administrative obstacles in seeking medical attention

The findings show that none of the female inmates paid a bribe to access medical health care. However, the converse is true for the male inmates. In the case of male inmates, however, 48.3% were forced to pay a bribe while 51.7% reported that they never did so. It was worthy of note none of the female inmates interviewed had given a bribe. Amongst the male inmates, 10% stated that bribery was the main reason that hindered their access to health care while in confinement.

Figure 9: Incidence of bribing



Apart from bribery claims, (20%) for the male respondents cited discrimination, preferential treatment and harassment of the inmates by warders as an obstacle to seeking medical attention. Amongst the male inmates, 34.6% reported that the existence of the long queues was a critical factor in deciding when to seek medical attention. None of the female inmates considered this a problem and it therefore did not arise when they decided to seek treatment. The anticipated bureaucracy and negative attitude by medical personnel and prison warders was the other factor that inmates complained about. This accounted for 19.2% and 12.5% of the male and female inmates' responses respectively.

On the other hand, only 8.3% of the female inmates felt that discrimination and harassment was a major hindrance to their access to health care. Other factors (8.3%) included delays, long queues and pathetic conditions. Bureaucracies in the prison administration were also a hindering factor. For instance, in the case where tests were to be done, 40% of the female inmates stated that they were given reasons why the same could not be done. Only 7.1% of the male inmates said they were given reasons. They gave up following the tests because of the bureaucracies.

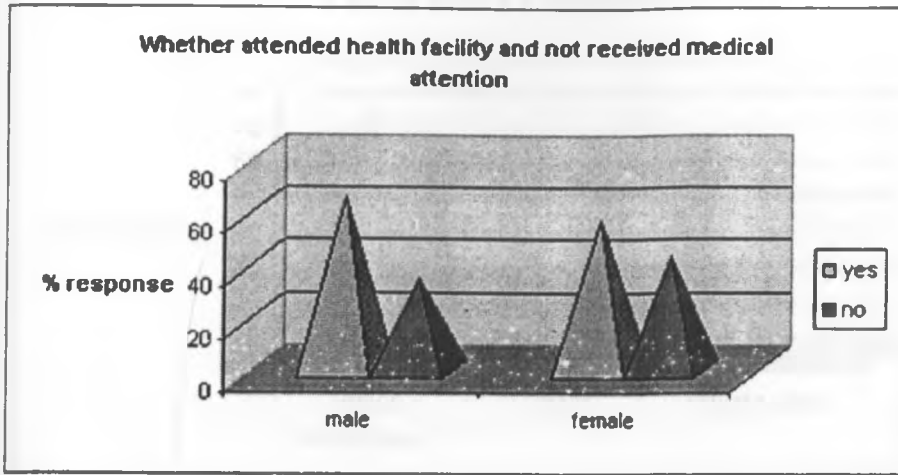
4.4.2. Lack of essential medicines

Lack of medical personnel and essential medicines was an issue emphasized by the key respondents. The non-governmental organization official was also of the view that the prison dispensaries lacked essential medicines and adequate medical personnel.

The police official was of the view that there was lack of essential medicines in prison dispensaries and lack of special diets due to lack of financial constraints. He recommended an increase in medical personnel and essential medicine as a way of ensuring that inmates receive treatment as and when they require it.

Lack of resources namely essential medicines, medical personnel and medical facilities accounted for 15.2% (male) and 12.6% (female) responses. The findings show that 65.5% of the male respondents failed to get medical attention of any kind. This was compared to 56.5% of the female respondents who were interviewed. This has been illustrated in Figure 10 below.

Figure 10: Inability to access health care

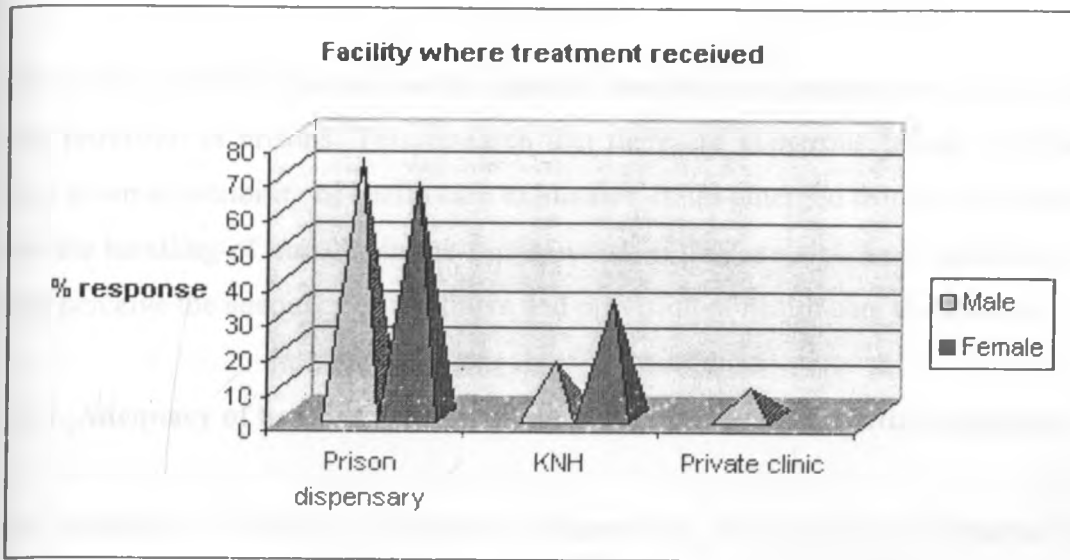


The findings show that 68.2% of the female inmates reported to have received medicine at the health facility compared to 56% of the male inmates. For those who did not get any medicine, 28.6% of the female inmates indicated that they received alternative treatment. Only 10% of the male inmates reported that they had managed to obtain alternative treatment. The public health officer stated that there had been a shortage of drugs at Kenya Medical Supplies Association (KEMSA) in the past preceding few months as a result of which the prison had not had adequate supplies of essential medicines. However, he emphasized that the non-governmental Organisation was assisting in the supplies of essential drugs, provision of footballs, volleyballs and in door games to curb idleness and reduce stress related ailments. All in all 70% of the male respondents compared to 8.3% of the female respondents felt that improper drugs or no medicine at all was a major hindrance to their accessing health care in prisons.

4.4.3. Lack of medical personnel

At the Lang'ata Women's Prison, although 1 clinical officer had been attached to the prison, he rarely attended the prison dispensary due to pressure of work in other government health facilities. It was the view of the public health officer that the 3 Public Health Officers were too few to deal with the large number of inmates at the prison. His observation was that the queues at the prison dispensary were long as a result of which many male inmates went back to the wards without having received any treatment.

Figure 11: Facility where treatment received



Out of the inmates who sought treatment, 73.1% (male) and 66.7% (female) received medical attention at the prison dispensary. On the other hand 33.3% of the female inmates and 15.4 % of the male inmates received treatment at Kenyatta National Hospital. These findings show that women were more likely to get better health care as they got more referrals.

Similarly, medical personnel who were more qualified treated female inmates. The data shows that nurses and doctors treated 58.3% and 41.7% of the female inmates respectively. On the other hand, nurses and doctors treated only 20.8% and 37.5% of the male inmates respectively. The rest (37.5%) of the respondents were treated by paramedics. None of the female inmates reported to have been treated by a paramedic. The large number of male inmates at the Nairobi Area/Remand Allocation meant that the 2 clinical officers assigned to the prison could not cope with the huge number of sick inmates. The public health officer stated that he helped in administering injections and drugs if there was a shortage of medical personnel.

4.4.4. Lack of essential facilities

The nurse-in-charge stated that the referral hospitals there are times inmates were not able to have x-rays taken thus compromising their health condition. These were sometimes lacking in the referral hospitals. The Nairobi Remand/ Allocation prison, however, had adequate supplies of gloves, syringes and gauzes.

4.5. Attitudes of inmates regarding adequacy of treatment in prisons.

The fourth specific objective was to establish the attitudes inmates had regarding health care provision in prisons. This research that there are numerous factors that hinder or slow down accessibility of health care to inmates. It has emerged from the findings below that the handling of inmates in the 2 prisons when they are sick have a bearing on how they perceive the adequacy of treatment and provision of health care to inmates.

4.5.1. Adequacy of health facilities, medical personnel and essential medicines

The treatment of female respondents compared to their male counterparts helps to highlight the attitude of inmates regarding the adequacy of the health facilities to cater for the health needs of the inmates in prisons in Kenya. The prison wardress at Lang'ata Women's prison emphasised that inmates were given priority when they attended the referral hospitals. She further indicated that she was not aware of any health concerns that inmates may have had. It was her opinion that the treatment given to the inmates was good and that there were adequate resources to cater for the medical needs of the inmates.

From the research conducted, it is clear that female respondents were able to obtain essential medicines and were treated by doctors and nurses. This is not the case for their male counterparts who reported that they were treated mainly by paramedics (37.5%) and that improper drugs were dispensed (43.8%). A majority of the female respondents (63.6%) reported that they were satisfied with the services at the health facilities because they had recovered fully from their illnesses. This is in contrast to 30.8% of the male respondents said this was their reason for their satisfaction. The female respondents were also satisfied because the treatment received at the health facility was humane (18.2%). None of the male respondents cited humane treatment as a reason for their satisfaction. Indeed, 12.5% of the male respondents were dissatisfied with the treatment at the health facility because of inhumane treatment. The data shows that no female respondent complained of dissatisfaction on this ground.

It is also instructive to note that 57.1% of the male inmates reported that there was no change in the management of their diseases during the different times they sought treatment. On the other hand, only 30% of the female respondents stated that there was

no difference. Female respondents also managed to get referrals to better health facilities, which had x-ray and laboratory facilities such as Kenyatta National Hospital (33.3%). This is compared to 22.2% of the male respondents. In addition, 73.1% of the male respondents received treatment at the prison dispensary, which as has been seen above lacked essential medicines. Where tests had been ordered but not done, 92.9% of the male respondents reported that they were not given any reasons why the same were not done. Only 60% of the female respondents stated that they were not given any explanations on the inability to do so.

The police official was aware that inmates obtained court orders to compel the prison authorities to take them to the prison dispensary or referrals at a public hospital for further management of the illness. More male respondents (58.6%) had to seek the intervention of the court to obtain medical attention. This is compared to 43.5 % of the female respondents. Indeed, when court intervention was sought, 50% of the female respondents managed to obtain treatment. However, 52.9% of the male respondents stated that the court orders were not complied with. Where the court orders were ignored, both male (41.7%) and female (30.8%) respondents gave up and took no further action.

4.5.2. Reforms in the prisons

From the study it emerged that 13.3% (male) and 17.2% (female) were not aware of any prison reforms. However, the rest stated that they were aware the reforms included comfortable transport, improvement of human rights, decongestion of prisons, provision of paralegal assistance and educational facilities, abolishment of corporal punishment, improved diet and access to the media. It was the opinion of 58.6% of the female respondents that the current health reforms addressed health concerns of inmates. This is compared to 23.3% of the male respondents.

The nurse in charge at the Lang'ata Women's prison felt that the transport provided prompt transport to the referral hospitals. With the introduction of TV sets, videos, computers and a hairstyling school, there was a reduced frequency of inmates complaining of stress related disorders which were previously caused by idleness and subsequent seeking of medical attention. The improved diet and purchase of bread and milk from the canteen had improved the health of the inmates. The open door policy had

also permitted well-wishers to donate foodstuffs and medicine to the inmates. However, the only complaint she was aware of from the inmates was that of poor diet. Similarly, the Police Prosecutor felt that the reforms, which had brought about comfortable transportation to court and provision of sanitary pads to the female inmates was a step in the right direction. He was, however, of the view that prisons ought to comply with orders from the doctors regarding provision of special diet.

A large number (55.2%) of the female respondents felt that the government was committed in addressing the health concerns of inmates. This was compared to only 46.7% of the male respondents who felt that the reforms were positive as regards their health concerns.

The respondents who were interviewed were of the view that the inmates' confidence regarding the health care system in prisons was very weak. This accounted for 43.3% (male) and 41.1% (female) responses. However, it is evident from the data collected that female respondents appeared to have a more positive attitude towards the health care provision to inmates compared to their male counterparts.

The inadequacy of the health care provision in the case of male respondents is particularly evident from their responses regarding the rating of the treatment received by inmates in Kenya. Out of male respondents who were interviewed, a small number (10%) felt that treatment received by inmates was fair, 36.7% felt it was poor and 46.7% rated it as very poor. On the other hand, the female respondents rated it as fair (31%), poor (24%) and very poor (24.1%) respectively. This is reflected in the data shown in Table 7 below.

Table 7: Rating of treatment in prisons

Rating of treatment of inmates in Kenya	Respondents Gender		Total
	Male	Female	
Excellent		3.4%	1.7%
Very good		6.9%	3.4%
Good	6.7%	10.3%	8.5%
Fair	10%	31%	20.3%
Poor	36.7%	24.1%	30.5%
Very poor	46.7%	24.1%	35.6%
Total	100%	100%	100%

Similarly, the female respondents (24.1%) were of the view that the quality of service provided in the health facilities they visited in prison as being good. An additional 20.7% of the female respondents opined that the quality was fair. This was quite high compared to the male respondents who reported that the quality was poor (43.3%) and very poor (36.7%). It is instructive to note that not a single male respondent thought the quality of health care as having been very good. This is compared to 6.9% of the female respondents. This has been demonstrated in the table below.

Consequently, from the data collected it is clear that female respondents generally had a more positive attitude regarding the management of their diseases and treatment while in confinement. This is demonstrated by the summary in Table 8 below.

Table 8: Rating of quality of care in health facilities in prisons

Rating of health care in prison facilities	Respondents Gender		Total
	Male	Female	
Excellent	3.3%	3.4%	3.4%
Very good		6.9%	3.4%
Good	3.3%	24.1%	13.6%
Fair	13.3%	20.7%	16.9%
Poor	43.3%	13.8%	28.8%
Very poor	36.7%	31%	33.9%
Total	100%	100%	100%

4.7. Priority areas requiring urgent attention

Despite the positive outlook on the part of the female respondents, both male and female respondents were of the view that several issues needed to be addressed to improve the provision of health care in prisons. These included spread of contagious diseases, lack of counseling for HIV/AIDS patients (6.7%), accidents in prisons (3.3%), congestion in prisons (3.3%), delays in medical attention (3.3%) and negative attitude of medical personnel (3.3%).

However, majority of them felt that the issues relating to unavailability of essential medicines and medical personnel lack of proper nutrition, problems relating to food poisoning and hygiene and sanitation were the most urgent. In the order of priority, the

male (16.7%) and female (24.1%) inmates respectively recommended that the problem of lack of essential medicines be addressed as a matter of urgency. On the other hand, the male (13.3%) and female (13.8%) respondents respectively thought that lack of proper nutrition needed urgent attention. Another 13.3% and 10.3% of the male and female respondents respectively were of the view that hygiene and sanitation were the most important issues. It is instructive to note that none of the female inmates complained of food poisoning. However, 16.7% of the male inmates reported that they had suffered from this problem.

Both male and female respondents (100%) were unanimous that the prisons required assistance from outside the system to improve the provision of health care to inmates. Out of these, 90% of the male respondents were of the view that it was the responsibility of the government and non-governmental organizations to look into the welfare of the health needs of the inmates. The remaining 10% of the male respondents felt that it was the responsibility of the prison authorities. The responses by the female respondents was more varied. The data also shows that 34.3% of the female respondents felt that it was the responsibility of the government and non-governmental organisations, 17.2% felt that it was the duty of prison authorities. In addition, 10.3 % said that it was the duty of the prison medical personnel and referral hospitals. Another 10.3% felt that the Officer in charge of prisons was the one to address the issues at hand.

On his part, the social worker at Nairobi Remand/Allocation felt that there was need to allocate more resources to prisons so as to meet the health care needs of the inmates. He recommended that prison officers be trained as medical professionals so as to treat the patients. Further, he proposed that hospitals be constructed in the prison premises to reduce the risk of escape of prisoners when they were being taken to referral hospitals, which are outside the prison premises.

Similarly, the judicial officer recommended a more comprehensive reform encompassing the general well-being of an individual while confined in prison. The failure of the prison systems had forced the courts to intervene to ensure that the health needs of the inmates were met. This had, however, caused friction between the judiciary and the prison authorities that feel that the judiciary is interfering in their domain.

The Office in charge at Nairobi Remand/Allocation Prison observed was of the opinion that TB, typhoid and malaria were the main illnesses that inmates suffer from. Consequently, there was a need to address this issue urgently to ensure that inmates enjoyed good health.

4.8 Provision of health care to inmates as a basic human right.

The research also attempted to answer the question whether the respondents considered provision of health care to inmates as a basic human right. The responses are shown in the table below.

Table 9: Health as a human rights issue

Do you consider provision of health care to inmates is a basic human right	Respondents Gender		Total
	Male	Female	
Yes	80%	93.1%	86.4%
No	20%	6.9%	13.6%
Total	100%	100%	100%

The analysis of data shows that 80% of the male respondents felt that inmates were entitled as a basic human right. A big percentage (20%) of the males felt that it was not a basic human right. This is compared to the huge percentage (93.1%) of female respondents who considered provision of medical care to inmates a basic human right for inmates to receive medical treatment. Only 6.9% of the female respondents felt that it was not a basic right. The response could be attributed to the fact that there were more females from urban areas compared to the male respondents who as has been explained above would be expected to be discerning than their counterparts from rural areas.

5.0. Background

The study was conducted with a view to establishing whether there was any notable difference regarding the access and provision of health care in prisons amongst inmates and whether this was differentiated by gender.

5.1. Summary of findings

5.1.1. Common ailments

One of the objectives of this study was to establish the common ailments that affected both male and female inmates. It emerged from the study that colds and malaria were the most common ailments affecting male inmates. Malaria was also the most common ailment amongst the female inmates followed closely by asthma and colds. A very small number of males reported of suffering from asthma. Diarrhoea was also a common complaint by those sexes. The inmates attributed the stomach problems to the poor preparation of the food. It was the view of a key respondent that lack of water was a contributory factor to poor sanitation and water borne diseases such as diarrhoea and typhoid, which was a common problem amongst the male inmates. Depression and headaches was a frequent complaint amongst the female inmates, conditions that none of the male inmates who were interviewed complained about.

Fungal infections and skin diseases did not appear to be a major concern for both the male and female inmates. This could be attributed to regular disinfection of their clothing and the education on hygiene and cleanliness. At the Nairobi Remand/ Allocation prison, this sanitation was the responsibility of the Public Health Officer who was assisted by fellow inmates to ensure all inmates bathed at least once a day.

5.1.2. Delivery of health care

The study showed that there was an elaborate system of how health care was delivered in prisons. Though structured and rigid, the dispensaries at both prisons were open to 24 hours and were manned by a medical person. Transport was also available 24 hours to

ensure that inmates could be transferred to referral hospitals at any time of the day and night particularly in the case of emergencies. Inmates were able to access VCTs, which were within the prison precincts. Lang'ata Women's prison was better served as there were fewer inmates compared to the Nairobi Remand/Allocation prison. However, there were not enough medical personnel and essential drugs to ensure that quality health care was provided to the inmates in both prisons.

The rules were very clear about the responsibility of each officer in ensuring delivery of health care to inmates and the consequences of such omission. Such omission could lead to disciplinary measures being taken against a negligent prison officer. The medical personnel were answerable to the Ministry of Health from where they were seconded. Tight security was an important issue all inmates were guarded 24 hours a day whether they were sick or healthy.

The inmates were all aware that provision of health care was a basic human right and despite the fact that they were not able to canvass for better provision of health care. However, reforms in the prisons were a pointer in the right direction for inmates in Kenya.

5.1.3. Factors affecting access of health care

It emerged from the study that females were more likely to seek medical attention than the males while in confinement. In addition, female inmates were more likely to access better medical attention than the male inmates. The analysed data showed that female respondents visited the health facilities more frequently than their male counterparts. This was despite the fact that the male respondents appeared to have suffered from more serious illnesses. This could be attributed to the female's level of education and urban residential status. It was expected that literacy and place of residence greatly contributed to an individual's perception to his health care as he was well informed.

From the data collected it can also be said that frequency within which male respondents sought medical treatment could be attributed to lack of adequate medical personnel and essential medicines. The few medical personnel in the prison facilities were unable to cope with the high male population at Nairobi Remand/Allocation.

On the issue of accessibility of better health care while in prison, the data collected showed that more qualified medical personnel treated the female inmates compared to their male counterparts. Majority of the female inmates reported that they recovered from illnesses and said they had received referrals when recommended. The positive ratings by the female respondents regarding the quality of health care were indicative of the fact that they felt the treatment given was adequate. The findings showed that the female inmates appeared to have relatively better health care provision compared to their male counterparts. The open door policy had encouraged well-wishers to participate in improving the general welfare of female inmates at Lang'ata Women's Prison. This could have been due to the fact that the prison was not as congested as the Nairobi Remand/Allocation, which houses the male offenders.

5.1.4 Attitudes of inmates towards delivery of health care in prisons

Female inmates were able to access health care within short durations without necessarily having to pay bribes. They were more assertive and sought help from the court whenever they encountered difficulties. The female inmates were also treated by more qualified medical personnel and were able to access essential medicines in higher proportions as compared to the male inmates. All these factors contributed to the favourable rating that the prisons got from female inmates.

On the other hand, it appeared from the findings that a male inmate was more likely to be worse off as far as his health status was concerned. The researcher observed that the male inmates had to squat while awaiting treatment at the prison dispensary and were crowded in a small area. It is for this reason that the male inmates gave poor ratings for the delivery of health care in prisons.

It can therefore be concluded that female inmates had a more positive outlook towards provision of health care as compared to their male counterparts.

5.2 Research recommendations

It emerged from the research that part of the problems facing health care provision in prisons was managerial in nature. There was low motivation and lack of commitment

amongst the prison warders in the way they treated inmates. There is therefore need to emphasise a cultural change to effect a more positive attitude towards inmates by both the medical personnel and prison authorities. Several studies had shown that if management problems were addressed, health care systems in Africa could be improved (Amondo-Lartson, 1994). The prison authorities and the doctors would be more sensitive to acknowledge comprehensive reforms encompassing the general well-being of inmates such as providing special diet when recommended by doctors and improving of the diet and not merely endeavouring to implement reforms which were only documented on paper.

The managerial problems were compounded by a lack of both financial and human resources. The prisons lacked diagnostic equipment and vehicles to transport inmates to referral hospitals. The health facilities in prisons were overwhelmed by the huge numbers of inmates in the prison. The long queues and congestion at the prison dispensaries meant that a big proportion of inmates was unable to access health care while in confinement. There was need for the government to increase budgetary allocations to meet the health needs of inmates. This would ensure provision of adequate supplies of essential medicines, deployment of more medical personnel in prisons and construction of health institutions with adequate facilities within the prisons' premises. Spatial distribution of health care facilities is critical due to the large numbers of inmates in prisons. The fair allocation of resources would ensure equity in that no one including the inmates would be denied access to essential health care.

Political will, consistent focus and monitoring of equity is crucial (Adetokunbo, 2004). For instance, the Tanzanian government showed its commitment to provide equitable distribution of social services to all its citizens through the Arusha Declaration of 1967. However, it was not until 1972 that the government adopted the principle in the health sector (Mnyika *et al*, 2004). In Kenya, the political will on ensuring equitable distribution of health care can be deduced from the government's commitment in implementing reforms in the health sector. This includes the introduction of the NSHIF Bill. However, this Bill is yet to be passed into law. The delay in passing the said Bill can largely be attributed to the political climate prevailing presently.

The policy position is therefore clear on the need to address equity and sustainability of quality health care delivery and collaboration with non-state actors. Health sector reforms in terms of the introduction of cost-sharing, exemptions and waivers are all largely aimed at addressing affordability and access to health care especially amongst the lower socio-economic groups.

In addition to deploying more medical personnel in prisons, there would also be a need to emphasise on the deployment of personnel who would meet the needs which were relevant to the inmates. Inmates suffered from diseases that could be controlled and managed by preventive health care. It was important to improve hygiene and sanitation to reduce the incidence of the diseases in the first place. Currently, wrong kinds of services were being provided in prisons and the curative approach had taken precedence. The expenditure on the hospital-based approach was exceedingly high but could be reduced if it re-routed to promote primary health care. It was commendable that the Nairobi Remand/Allocation had embarked on a programme to sensitise the inmates regarding preventive health care.

The general well-being of inmates is critical not only as a human rights issue but also for ensuring that justice is not delayed or denied. It emerged that judicial work was hampered when remandees were unable to follow their cases because of illness. This created a lot of backlog of cases in the courts translating into longer periods without receiving a trial. The ill-health against a backdrop of facilities with inadequate resources would eventually impact negatively on the health of inmates. It would be important for the government to emphasise on the importance of Community Service Orders with a view to decongesting the prisons. This can be achieved by cultivating collaboration between the judiciary and prison authorities.

Public health policies are meant to ensure the best possible conditions for all members of society so that everyone can be healthy. Inmates are a vulnerable group that requires quality health care and are quite often forgotten in this equation. Prisoners enter and leave prisons and are released if found innocent. In addition, inmates are eventually reintegrated into the society. If they are not healthy, they are likely to impact negatively on the government's efforts to eradicate or alleviate poverty. There is no doubt that an unhealthy population cannot be economically productive.

This study showed that there was need for the government to provide policy frameworks, which would ensure that each and every citizen was able to access formal health care whether free or in incarceration. This was to be irrespective of his socio-economic class or gender. The prioritization of the planning process for the provision of health care in prisons was urgently required so as to effectively address the medical needs of prisoners.

Despite the many challenges faced by all inmates, it was evident from the findings that the male inmates were more affected when seeking medical attention while in confinement than their female counterparts. Gender disparity appeared as a critical issue when organizing the provision of health care to inmates in prisons. It was therefore important for the prison health care delivery to be reviewed for effective administration of human rights to prisoners and more particularly in the case of men. This would ensure equal treatment without discrimination on the basis of gender.

5.3. Recommendations of areas for further research

During the research, it emerged that there were several areas that required further exploration to ensure that a holistic approach was attained for effective provision of health care to prisoners. The responsibility of providing health care to inmates lay with the government which was facing challenges in providing health care to inmates. There was consequently need for further studies to examine the role of prisons in providing health care and the challenges they faced in health care provision for inmates.

The prisons are provided under the direction of the government which has been facing challenges in the provision of health care for a large proportion of its population in light of the overall inadequate budget. A study could be conducted to establish the extent of the challenges that the government faces in providing health care to inmates with a view to formulating policies on health provision focusing specifically on the needs of inmates.

It emerged from the study that hygiene and sanitation conditions in prisons ought to be improved. The high incidence of malaria and diarrhoea which are water borne diseases could be reduced if the environment was sanitized. Consequently, a study could be

conducted to establish the extent and impact of the environment as a contributor to the ill-health of inmates with a view to looking for ways to tackle the problem.

Bribery emerged as a major hindrance for male inmates when seeking medical attention in prisons. Inmates come from various socio-economic groups. While it is generally agreed that one would need finances to have a comfortable stay in prison, it is not clear of the extent of which lack of finances could prevent one from accessing health care at all. Hence, a study could be conducted to determine the extent to which socio-economic factors impact on the access to health care.

The data collected revealed that there are times when inmates visited health care facilities while in confinement and they were unable to access health care due to a variety of reasons. It would therefore be important to carry out research to assess the impact of confinement on the health status of inmates once they are re-integrated in the society.

In view of the fact that inmates are outputs processed through different systems, there would be need to establish the significance of the link between the judiciary, prisons and the general health care systems ensuring health care is provided to the inmates as and when the same is required. Though not exhaustive, these studies would enable scholars come up with recommendations to alleviate the suffering of inmates in Kenya.

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Introduction

Appendix A

My name is Jacqueline Kamau from the University of Nairobi Department of Sociology. I am carrying out research on the accessibility of health care amongst male and female inmates. The study has been approved by the Ministry of Education, Science and Technology and I was issued with research permit no. MOEST 13/001/35C566. The information is for academic advancement to inform policy in the government. The information that you will give me will be treated with utmost confidentiality. Please answer the questions as honestly as possible. Your co-operation in this study will be highly appreciated.

Questionnaires for inmates

Section A

1. Name: _____
2. Age group: 1. 18-25 2. 25-30 3. 30-35 4. 35-40
3. Sex 1. Male 2. Female
4. Marital status 1. Married 2. Divorced 3. Single 4. Widowed
1. Nationality _____
2. Religion 1. Christian 2. Muslim 3. Hindu 4. Other _____
3. Place of birth _____
6. Number of children/dependents _____
7. Residence before confinement: _____
8. Occupation before confinement: _____
9. Level of education attained
 - a. No education
 - b. Primary Education
 - c. Secondary Education
 - d. College Education
 - e. University Education

10. Monthly income before confinement:

- a. Below Kshs 3,000/=
- b. Kshs 3,100/= - Kshs 6000/=
- c. Kshs 6,100/=- Kshs 9,000/=
- d. Kshs 9,100/=- Kshs 12,000/=
- e. Above 12,100/=

11. Residence of spouse/parent/guardian: _____

12. Occupation of spouse/parent/guardian: _____

13. Income of spouse/parent/guardian: _____

14. What offence have you been charged with ? _____

15. Have you been convicted of the offence? 1. Yes 2. No

16. What is the duration of your sentence?

- a. less than 6 months
- b. 7 months- 12 months
- c. 13 months- 18 months
- d. 19 months- 24 months
- e. more than 24 months

17. If you have not been convicted, how long have you been in custody?

- a. 1 month -6 months
- b. 7 months -12 months
- c. 13 months-18 months
- d. 19 months -24 months
- e. Over 24 months

18. Before your confinement, which health facility (ties) did you normally attend to seek treatment for your illnesses?

- a. City Council dispensary
- b. Public referral hospital

c. Small scale private clinic

d. Large private hospital

17. Were you required to pay any fees before receiving treatment? 1. Yes 2. No

18. Was there a time you were not be treated due to lack of money? 1. Yes 2. No

19. Did you seek alternative treatment for your illness? 1. Yes 2. No

20. If yes, what kind of treatment did you receive? _____

21. If not, what were the factors that hindered you from doing so? _____

22. Have you ever fallen sick while in confinement? 1. Yes 2. No

23. What type(s) of sickness have you suffered from? _____

24. What type of sickness have you frequently suffered from while in confinement?

25. What was the duration of the most recent episode of the illness?

a. Less than 3 days

b. 4-7 days

c. 8-10 days

d. 11-14 days

e. Other _____

26. Did you seek medical attention? 1. Yes 2. No

27. How long did you take before you sought treatment?

a. 1-2 days

b. 3-7 days

c. Over 7 days

28. What factors determined the duration of time you took to seek medical care?

29. Where did you receive treatment for the last episode of sickness?

- a. Prison dispensary
- b. City Council dispensary
- c. Kenyatta National Hospital
- d. Private clinic
- e. Other _____

30. Who attended to you when you sought treatment?

- a. Paramedic
- b. Nurse
- c. Doctor
- d. Other _____
- e. I don't know

31. What duration of time did you spend at the health facility while awaiting treatment? _____

32. What treatment did you receive? _____

33. Were any tests ordered to investigate the nature of your illness? 1 Yes 2. No

34. Were the tests carried out? 1. Yes 2. No

35. If not, were you given any reasons why the tests were not done? 1. Yes 2. No

36. Did you get the medicines that were prescribed at the health facility? 1. Yes 2. No

37. If not, were you given alternative treatment? 1. Yes 2. No

38. Did you recover after the treatment? 1. Yes 2. No

39. If not, were you referred to another health facility? 1. Yes 2. No

40. How long did it take before you were referred to that facility?

a. 1-2 days

b. 3-7 days

c. Over 7 days

41. Did you feel satisfied with the treatment you received from the time you fell ill ?

1. Yes 2. No

42. If yes, what were the reasons for your satisfaction? _____

43. If not, what were the reasons for your dissatisfaction? _____

44. Was the management of your last episode of disease different from the other times that you were sick? 1. Yes 2. No

45. If so, please explain how this was different _____

46. While in confinement have you ever attended a health facility and not received medical attention? 1. Yes 2. No

47. What factors prevented you from accessing health care? _____

48. Did you take alternative measures to manage the illness? 1. Yes 2. No

49. If yes, what measures did you take? _____

50. Did you recover from the illness? 1. Yes 2. No

51. If you did not, did you eventually recover from the illness? 1. Yes 2. No

52. While in confinement, have you ever been treated at a health facility of your choice? 1. Yes 2. No

53. While in confinement have you ever given a bribe to anyone so as to influence treatment of your illness in a health facility of your choice? 1. Yes 2. No

54. If yes, where were you treated?

- a. Prison dispensary
- b. City Council dispensary
- c. Kenyatta National Hospital
- d. Private clinic

Other _____

55. Have you ever requested the court to be taken to hospital? 1. Yes 2. No

56. If yes, were the court orders complied with? 1. Yes 2. No

57. If not, what action did you take? _____

58. If you did not taken any action, what were the reasons that prevented you from doing so?

a. Fear of the authorities.

b. I did not know the procedure to follow.

c. Other _____

59. Do you consider the provision of health care to inmates a basic human right? 1. Yes 2. No

60. At present what major complaint do you have regarding your health?

Section B

Perception of adequacy of health care facilities

1. What would you say about the general health care provided in facilities that you have attended in Kenya?

1. Excellent 2. Very good 3. Good 4. Fair 5. Poor 6. Very poor

2. How would you rate the treatment received by inmates in Kenya when they are ill?

1. Excellent 2. Very good 3. Good 4. Fair 5. Poor 6. Very poor

3. How would you rate the quality of services in the health facilities that inmates attend for treatment?

1. Excellent 2. Very good 3. Good 4. Fair 5. Poor 6. Very poor

4. What prison reforms in Kenya are you aware of? _____

5. How would you rate the reforms ?

1. Excellent 2. Very good 3. Good 4. Fair 5. Poor 6. Very poor

6. In your opinion, have the prison reforms addressed inmates' health concerns? 1. Yes 2. No

7. In your opinion what is the main complaint about provision of health care for inmates in Kenya? _____

8. Do you think the government is committed in addressing the health concerns of inmates? 1. Yes 2. No

8. In your view, what is the level of confidence of inmates in the health care system? 1. Very strong 2. Strong 3. Fair 4. Weak 5. Very weak

Section C

Long term intervention strategies

1. What health issues for inmates need to be addressed urgently?

2. Who should address the issues concerning the health of inmates?

3. Which other institutions can co-operate to address issues concerning the health of inmates? _____

4. What do you think would be the most efficient action that could be taken to ensure that inmates enjoy good health? _____

Thank you very much for your co-operation

Introduction

Appendix B

My name is Jacqueline Kamau from the University of Nairobi Department of Sociology. I am carrying out research on the accessibility of health care amongst male and female inmates. The study has been approved by the Ministry of Education, Science and Technology and I was issued with research permit no. MOEST 13/001/35C566. The information is for academic advancement to inform policy in the government. I will proceed to ask questions to guide this discussion. Please feel free to participate and ask any questions to clarify issues which may not be clear to you. The information that you will give me will be treated with utmost confidentiality. This discussion may last for one (1) hour. Please answer the questions as honestly as possible. Your co-operation in this study will be highly appreciated.

Discussion guide questionnaire for key respondents

Section A

1. Name
2. Occupation
3. Name of organization
4. Duties and responsibilities at the department or service.
5. Encounter with the issue of health of inmates in the course of work
6. Knowledge of types of sicknesses.
7. Level of involvement
8. Mechanism of dealing with the health issue of inmates.
9. Assistance given to the inmates.
10. Adequacy of resources to offer treatment to inmates
11. Mode of payment after treatment of inmates.
12. Mechanisms for monitoring the progress of the inmates' health after treatment.
13. Appointments and reviews.

14. Extent of impact of the ill health of inmates in the organization.
15. Opinion on the general health care system in Kenya
16. Opinion on the adequacy of treatment of inmates' illnesses in Kenya.
17. Views on prison reforms in Kenya and whether these address the health concerns of inmates.
18. Major complaint of inmates about the provision of health care.

Thank you very much for your co-operation

Appendix C

Observation checklist

- Method of reporting illnesses
- Qualifications of medical personnel
- Availability of essential medicines
- Security measures
- Reviewing of progress of the health of inmates
- Procedure of referrals
- Number and proximity of health facilities within the prison premises
- Availability of external assistance
- Interaction of medical personnel and inmates
- General appearance of inmates
- Availability of drugs