Integrating Constitutional Values and Principles and the Rights Based Approach in the Operational Frameworks of County Health Care Facilities

2015

Assessment Report for Kitui County

County Government of Kitui
PO Box 460-90200, Kitui

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ASSESSMENT REPORT FOR KITUI COUNTY

Submitted by:
The Commission for the Implementation of the Constitution (CIC)
Human Rights Thematic Area
31st August 2015

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Foreword

The Commission for the Implementation of the Constitution (CIC) is a transitional commission established by section 5 of the sixth schedule to the Constitution of Kenya, 2010 with the mandate of, among other things: monitoring, facilitating and overseeing the development of legislation and administrative procedures required to implement the Constitution.

In discharge of its mandate, CIC works with the national and county governments in the process of the development and review of policies, legislation and administrative procedures for the implementation of the constitution. As part of its facilitative mandate, CIC in collaboration with the county government of Kitui undertook a project of evaluating the operational frameworks of the health facilities in Kitui county with a view of identifying ways of ensuring that the county complies with its constitutional mandate of ensuring respect, protection, promotion and fulfilment of the fundamental rights and freedoms promoted and protected by the Constitution and the realisation of the national values and principles enshrined in Articles 10 and international human rights instruments ratified by Kenya.

The project was piloted in Kitui, Bungoma and Nyeri Counties with the intention of initiating processes of reducing the levels of human rights violations experienced by patients in different public health facilities including physical and verbal abuse, mistreatment and harassment, neglect and abandonment, humiliation, punishment, detention in health facilities for failure to pay hospital bills among others. The project objectives were (i) the review the County health facility operational frameworks against the constitutional provisions on the right to health and the national values and principles with a view to making recommendations to guide the county on what needs to be done to ensure compliance with the constitution (ii) the review of the county health facility service charters to incorporate the values and principles of the constitution (iii) the development of the capacities of county health sector teams on the right to health as provided by the constitution and on health as a devolved function. The Danish International Development Agency (DANIDA) supported this project. The project was also documented on video to facilitate learning for others.

This report is a summary of the project activities and findings for Kitui County. It also has the recommendations necessary to guide the county in the improvement of its health facility work culture in line with the constitutional requirements public service delivery.

CIC hope that the county government of Kitui will commence the process of implementing the recommendations of this report including the application of the revised health facility charters that have now incorporated the provisions of the constitution.

Signed:

……

Mr. Charles A. Nyachae
Chairperson,
Commission for the Implementation of the Constitution (CIC)

Executive Summary

Article 43(1)(a) of the Constitution of Kenya 2010 guarantees every person the right to the highest attainable standard of health, which includes the right to general healthcare services and reproductive health services. In keeping with its mandate to monitor and oversee the implementation of the Constitution and its strategic objective number four of strengthening institutional frameworks and administrative procedures, the Commission for the Implementation of the Constitution (CIC), with support from the Danish International Development Agency (DANIDA), and in consultation with the county government of Kitui undertook a review of the administrative and operational frameworks for County health facilities with the objective of finding out if the Constitutional requirement to integrate the values and principles of the constitution and rights-based approach is being applied in the delivery of health services.

The project entailed examining existing operational frameworks including management frameworks and systems and service charters, in order to assess their compliance with the Constitution, and in particular with Article 10, which contains the national values and principles that bind all public officers and should therefore guide the delivery of services to the public. The expected results of the project in the short-term were county health facility charters that are rights based and compliant with the Constitution of Kenya 2010. In the long term, it was expected that county health service facilities would espouse a work culture guided by the values and principles of the Constitution where the rights of service recipients are respected and protected and service providers are operating in an environment that enhances their outputs while respecting their rights. It is expected that the findings from the study will form a basis upon which future efforts to integrate constitutional values and principles in health service delivery may be modelled. This report focuses on the activities in and findings from Kitui County.

Methodology

Data was collected from all the levels of the public health service delivery in Kitui County. Client, staff and other key informant interviews and discussions formed the primary approach of data collection. The clients included male and female community residents using the facilities, ranging from 18 to over 65 years old. Health facility staff included administrative staff, medical personnel, allied health staff such as physiotherapists and

HIV testing and counselling personnel, and support staff. Key informant interviews were held with County health sector personnel as well as the management of the facilities. The study also employed assessment of facilities through observation. Review of national and county level operational frameworks including health sector laws and policies was also done.

Overall, 616 respondents were interviewed: 362 client interviews, 128 staff interviews, 33 interviews with key informants from various health facilities, 3 interviews with key informants from County and Sub-County health sector, and 10 focus group discussions and interviews with 86 members of the community were conducted. In addition, 48 health facilities were observed using a facility observation guide. 18 operational frameworks were reviewed – 2 from the County level and the rest from the National level. All the tools used in data collection were developed specifically for the study.

Key Findings

Availability

Facility availability: Kitui County has the highest number of facilities in the country with 230 operational public health facilities compared with the national standard of 106 for a population of 700,000. However the distribution of the facilities, particularly dispensaries and health centres, does not allow for equitable access. Chuluni Ward (Kitui East), Township (Kitui Central), Ikutha (Kitui South), Tharaka (Mwingi West), and Waita/ Endui (Mwingi Central) are underserved with community members walking for more than an hour in some areas to access the nearest health facility.

Staffing levels: Kitui is operating at 28% of the minimum required staff, contributing to the existing significant understaffing in the County health facilities. For instance, the Doctor to population ratio is 1:22,005 which is lower compared to the World Health Organization's recommendation of 1:10,000 and the nationally recommended standard of 1: 25,000; while the Nurse to population ratio is 1:1,962 against the recommended WHO ratio of 1:1000[1]. The critical shortage of staff was not only raised as a concern by the staff and managers, but also by the community members. An estimated 33.7% of the clients interviewed were aware that staffing levels were inadequate, particularly at dispensaries and health centres. The study found that the inadequacy of skilled human resources for health

1 Kitui County Integrated Development Plan, 2013-2017, p.40

affects the variety of services that are available, the number of hours over which services can be available, the waiting time, and even the quality of services delivered.

Supplies and equipment: the study found that there have been perceptible improvements since devolution in the supply of appropriate drugs. However, the adequacy and consistency of supply still remains low. While the County Integrated Development Plan 2013-2017 indicates an intention to increase specialized services such as X-ray machines, laboratories, surgical units, among others, the progress is slow.

Accessibility

Geographic access: the World Health Organization recommends a maximum of a 5km radius or 30 minutes access to the nearest health facility. Communities in Kitui travel an average of 10.2 km^2 to the nearest health facility. On the lower end, 51.2% in Kitui South live within a 5km radius and on the higher end, 98% in Kitui West are within a 5km radius. While majority (60%) of the respondents arrived at the facility within 30 minutes, others took longer. It was noted that community members particularly from Mwingi North and Mwingi Central sub-counties had the challenge of traveling for up to 1 hour or more to get to the healthcare facilities.

Economic access: majority of the clients interviewed (74.9%) did not pay for the services they received, most of which were delivered in health centres and dispensaries. These services include registration and thereafter consultation with the medical personnel. This is in keeping with the national policy of zero payment at Level 2 and 3 facilities. However, it is also important to note that the challenges of unavailability of supplies and specialized services and inadequate staffing levels were greatest in the Level 2 and 3 facilities, which can increase out-of-pocket expenses for the clients as they look elsewhere for the missing services.

Organizational access: relates to the organization, clarity and flow of services from one point to another within the facility, which either enables or impedes access for clients. It includes sitting areas, waiting times between different services, layout and ease of access to sections of the facility, among others. The study found that 60% were attended to after registration within 30 minutes while 18% had to wait for up to an hour for the first medical attendance. In total, half the population interviewed took less than an hour to be served while 17% took more than two hours. An estimated 27.9% of the respondents felt that the time taken to offer services is too long and should be reduced.

2 ibid

Access for persons with disabilities: 3% of the clients interviewed were persons with disabilities. These were found to be physical, visual, hearing and mental disabilities however, the study noted that client data cards and registration documents do not capture information on any disabilities that clients may have. This information would enable the County health system to put appropriate strategies in place to address the needs of persons with disabilities, according to their distribution within the County. All County hospitals (Level 4 and 5) had wheelchair access ramps, wheelchairs and gurneys. The adequacy of the equipment was not clear. On the other hand, up to 81% of dispensaries did not have wheelchair access ramps. Ensuring physical access for persons with disabilities, elderly persons and others who need help should continue to be an area that is prioritized in the delivery of healthcare services.

Information access: 62.5% of the facilities assessed had prominently displayed signs indicating services and costs as well as service charters. However, the study established that none of the clients interviewed relied on the signs to obtain information on where the services can be found within the facility. They either spoke to staff and other clients or used their prior knowledge of the facility to find what they needed. This is significant when determining multiple mediums of delivering information to community members.

It was significant that facilities use diverse communication channels such as health education talks within the health facility, Chief's *barazas*[3], religious (Church) gatherings, schools, Public Health Officers, and Community Health Workers/Volunteers where available to share information.

Acceptability

Privacy and confidentiality: up to 88% of clients assessed across the County were attended to in private. However, Kitui West facilities stood out in that slightly less than 50% stated they were not attended to in private.

HIV Care and Treatment: in 60.4% of the facilities, it was easy to identify the room or building dedicated for HIV care and treatment. While this separation of services ensures that persons living with HIV access quality health services, it can also be a barrier to access due to stigma.

Condom dispensers: only Kyuso District Hospital and Ngomeni Health Centre, both in Mwingi North, had stocked condom dispensers in the male toilets, out of the 48 facilities assessed. Placing the condom dispensers

3 Chief's barazas are meetings with community members organized by an area's Chief (the public administration officer responsible for a location) to discuss matters affecting the area residents and any government directives

within the toilets may make it easier for clients to access the condoms while in private.

Choice of facility: the top three criteria applied by clients when deciding which facility to go to were physical proximity of the facility, the range of services available at the facility, and the cost of the services. While cost was important, it was less important than proximity and range of services. Having a range of services available within the same facility reduced the amount of time and the distances travelled in receiving healthcare. It was also notable that public hospitals are the top choice for residents of Kitui County, indicating that there is a measure of trust that public health facilities enjoy among communities in the delivery of healthcare. Trust is an aspect of acceptability.

Quality

Cleanliness, sanitation and environment: nearly all the facilities assessed (over 83%) were clean, well ventilated and had clean toilets. However, incinerators and burners were found to be effective in only 41.7% of the facilities. This poses a challenge in assuring safety for the staff, clients and community as inappropriate disposal of the medical waste can contribute towards transmission of diseases.

Perceptions of quality: 90% of the clients were satisfied with the services received. In contrast only 69% thought that the facilities enjoyed a good reputation in the community. This begins to indicate that the public perception of the facilities is still fairly negative. Perceptions do not always reflect reality but are important to address when seeking to increase uptake of healthcare services and health practices within communities. The County should go further to understand the negative public perceptions of the facilities. Over 60% of staff interviewed felt that the way staff treated patients was a strong aspect of the quality of services provided. A further 80% felt that the inadequate staffing levels was the biggest barrier to quality services.

Feedback and participation: Although 80% of clients said they would be comfortable giving feedback, facility management noted that the suggestion boxes are hardly ever used. Clients also pointed out that they would prefer to give their feedback to a member of staff.

Service Charters: Approximately 65% of the facilities observed had a clear sign showing the Service Charter. Interestingly, while 93% of the staff felt that a Service Charter is important, up to 53% were unclear on why it is important. This could be an indication that the staff have not been

adequately educated on the importance of a Service Charter, and they therefore simply comply with the requirement to have one in the facility. It was noted that 71.28% of the staff from the facilities that have a Service Charter felt that it is not understood by all the clients, and suggested that it should be translated to different languages, communicated verbally, and simplified to make it easier for the clients to understand it. All the staff felt that service charters should communicate the services offered at the facility, 85.11% thought it should include the duration of services, and a further 54.26% felt it should include client rights, among other recommendations. The study found that in nearly all the facilities, the Service Charters had been reduced to notices indicating the services available, the cost of the services and in some cases, the length of time for the services. None of the facilities assessed had service charters that articulated the rights of clients and the standards of service that the facility was committed to providing. In addition, the Charters did not indicate who the manager or officer on duty is.

Conclusions and Recommendations

Kitui County has taken measures aimed at improving accessibility, availability, acceptability and quality of healthcare services. There are specific programs that have been commenced towards strengthening preventive measures, including environmental cleanliness and sanitation in communities, community health discussions, among others.

The County management is also aware of the particular challenges faced, including the related development challenges of roads and infrastructure, water scarcity, poverty and education levels. These issues have been prioritized in the County Integrated Development Plan (CIDP).

There is room for further initiatives based on a rights-based approach to address the gaps that the study begins to reveal. These include:

1. Whereas the Kitui County Integrated Development plan and the Health Facilities Management Bill 2014 properly address the recognition of health as a right and the need to plan with the right to health indicators, the County needs to integrate the values and principles of the constitution in the facility management Bill to guide service provision as contemplated by the constitution. The proposed facility management committees should have an additional responsibility to oversee the implementation of facility service charters and the work culture in the facilities.

2. Attending to the challenges of staffing levels, a health facility should

have adequate medical personnel whose skills cover the range of services needed at the facility level.

3. The inequitable distribution of health facilities in Kitui County is an issue that should be addressed. It may be necessary to plan for the temporary closure of some facilities in wards that are 'over-served' and put in place more facilities for those underserved in order to ensure equitable distribution of healthcare workers and of facilities.

4. The county government needs to invest in better health technologies and supplies of health commodities and drugs for improved health care.

5. The County needs to undertake a further analysis of the cost versus quality of service balance to determine the optimal financing model for health services that will assure adequacy of drugs, supplies, and staff.

6. The county health facilities should deliberately plan and periodically review their service delivery culture to introduce organisational operations that are efficient for the better management of the queues within hospitals.

7. The County government needs to review its health facility tools; like the registration cards to include excluded and marginalised groups like persons with disability.
8. The efforts to include all persons in health care should be comprehensive to ensure the equipment and personnel are well trained to serve all including persons with different disabilities, drug users among others.

9. The county needs to review the specific challenges facing some of the facilities in attending to patients in private. This is an important measure for ensuring the preservation of the right to confidentiality. Redressing this need will be a follow-up.

10. The County needs to review the practice of isolating the HIV care and treatment from other services because of the stigma that this brings and the possibility that some of those affected may not seek services at these facilities.

11. Privacy is an important aspect of acceptability of the condom provision services offered in many health facilities. The location of condom dispensers in the toilets may be more suitable for clients.

12. The county government should review its service delivery strategies to

provide a range of services in the same facilities to avoid the need for clients to walk long distances seeking services that will facilitate decision-making in the referring facility. Some of the services can also be offered through innovative methodologies like mobile clinics.

13. The county government should ensure that all health facilities have functional incinerators to process the medical waste and ensure the safety of staff, clients and community.

14. The county government should seek to understand the reason for the negative public perception on the facilities. This is through the encouragement of public participation in its planning and review activities, this will identify the issues that need to be addressed for better service delivery.

15. All health facilities should have an adequate supply of clean water to enhance the quality of the delivery of health services.

16. The county government should invest in diverse methods of communicating with community members on health matters; this may include having a customer care desk or designated officer to facilitate interaction with the public. The utilisation of the suggestion boxes should also be active to make this form of communication meaningful.

17. There is need to invest in more oral and audio forms of communication to better serve the clients at health facilities.

18. Continuously improving supply of medical equipment and drugs, and facilitating access for persons who need support in physical access to facilities, among others.

19. Service Charters should be made a part of the performance management system for individual members of staff; health facilities should also undertake regular assessments of the implementation of the Service Charter together with the facility management Committee and the community members. These dialogues around the Charter should encourage the celebration of achievements as well as the identification and resolution of challenges to adhering to the commitments contained in the Charter.

20. Politicians must learn to subject themselves to the health facility regulations and should not intimidate staff to act in a particular manner or to serve certain people as they direct.

Acknowledgements

This baseline assessment study was undertaken by the Commission for the Implementation of the Constitution (CIC) together with the County Government of Kitui with support from DANIDA and involved different stakeholders who participated and provided valuable information that enriched the report and we sincerely want to thank them for their contribution. The national oversight committee that helped in the quality control of the process and provided professional guidance at all levels and stages was made of representatives of the Ministry of health of the national Government, The Council of Governors (COG) representative, the Aga Khan Hospital, St. Mary's Hospital. The Kenya National Commission on Human rights (KNCHR), the National Gender and Equality Commission (NGEC), The Commission on Administrative Justice (CAJ), Action AID International (AAI), Kenya Legal and Ethical Network on HIV (KELIN), The National Council for Persons with Disabilities, The representative of media; The Kitui county project oversight team comprising of representatives from the Ministry of Health and Sanitation of Kitui and the County Government the project survey respondents from all over Kitui County - Kitui Central, Kitui Rural, Kitui South, Kitui East, Kitui West, Mwingi Central, Mwingi North Mwingi West Sub-Counties – for their cooperation in providing information that formed the basis of this report. The Public health and human rights consultants on the project Dr. Caroline Nyambura and Ms. Eva Ayiera who tirelessly worked to ensure the completion of this project, as well as, the communication consultant Mr. Mburugu Gikunda for documenting the process through audio-visual means, the project administrator Ms. Veronica Omunga in organizing and coordinating the project activities; and lastly the CIC team led by the Chairperson of the Commission Mr. Charles Nyachaye and his entire team of Commissioners as well as staff who were insightful in generating comments that shaped the activities of this project. In particular we are grateful to the CIC Project team led by Commissioner Catherine Muyeka Mumma, including Dr. Florence Omosa, Mr. Mugita Gesongo, Mr. James Wagala, Ms. Christine Kuria, Mr. Ahmed Anwar and Ms. Ruth Muthui for their insightful and professional guidance at every stage of the project.

Special thanks go to Alicia Ely Yamin from Harvard School of Public Health for her insights, guidance and contributions to increasing understanding on the rights based approach to health.

Acronyms

ACHPR	Africa Charter on Human and People's Rights Against Women
CBO	Community Based Organisation
CEDAW	Convention on the Elimination of All forms of Discrimination
CERD	Convention on Elimination of all forms of racial Discrimination
CIC	Commission for the Implementation of the Constitution
CIDP	County Integrated Development Plan
CRA	Commission for Revenue Allocation
CRC	Convention on the Rights of the Child
DANIDA	Danish International Development Agency
ICESCR	The International Covenant on Economic, Social and Cultural Rights
RBA	Rights-Based Approach

1.0 Introduction

1.1 Background

The Constitution and the Right to Health

The Constitution of Kenya 2010 has secured under Article 43 the right of every person to the highest attainable standard of health, which includes the right to healthcare services including reproductive health services, and the right to emergency medical treatment. The right health is also provided for in a number of provisions in the Constitution. These include Articles 53 (1) (c) and 46 which provide for the right of every child to adequate health care and the rights of consumers to the protection of their health, safety and economic interests respectively. By virtue of Article 2 of the Constitution, the health rights in international treaties ratified by Kenya including the United Nations Covenant on Economic Social and Cultural Rights (ICESCR), the United Nations Convention on the Elimination of All forms of Discrimination Against Women (CEDAW), the United Nations Convention on The Rights of the Child (CRC), the United Nations Convention on the Rights of Persons with Disabilities (CRPD), the African Charter on Human and Peoples Rights (ACHPR), the African Charter on the Rights and Welfare of the Child and other World Health Organisation treaties also form part of the laws of Kenya. Furthermore several articles are directly related to health. These include articles on the right to life, adequate housing, food, clean safe water and sanitation, social security and education.

The Constitution of Kenya has also prescribed values and principles that must guide public service delivery in all state organs. These include patriotism, national unity, sharing and devolution of power, the rule of law, democracy and participation of the people, human dignity, equity, social justice, inclusiveness, equality, human rights, non-discrimination and protection of the marginalised; good governance, integrity, transparency and accountability and sustainable development. Although there are no specific standards set on the implementation of the right to health, service providers are guided by the national values and principles of governance under Article 10 which include the rights based approach to service delivery; integrity, leadership and accountability specified in Chapter Six and values and principles of public service as stated in Chapter Twelve.

The Duty to implement the right to health

Article 20(1) provides that the bill of rights applies to all law and binds all state organs and all persons. Article 21 of the Constitution requires the State to put in place policy, legislative and other measures including the setting of standards to ensure the progressive realization of the rights in Article 43. The State includes the duty bearers at the national and county government levels.

Article 6 of the Constitution defines the new system of governance in Kenya. It creates a system of devolved government comprising of one National government and 47 Counties. These are distinct but inter-dependent and are expected to carry out their mutual relations through consultation and cooperation. The distinctiveness of the two levels of government is defined by the Fourth Schedule to the Constitution which assigns functions to either level of government and gives some semi-autonomous power in the decision making and management for the delivery of these functions. The inter-dependence is demonstrated in the manner in which the devolved functions have been shared between the two levels of government where the delivery on the aspects of functions assigned to one level is inter-linked to the actions of the other. To facilitate consultation and cooperation, the constitution has defined inter-governmental relations, which have been further elaborated in the Inter-Governmental relations Act 2012. Health is one of the devolved functions with the National Government having been assigned the responsibility of developing national health policies, setting standards to guide health service delivery, building the technical capacity of county governments to perform their functions, and direct responsibility over national health referral facilities. The County Governments have mandate over county health services, including the promotion of primary health care and the running of county health facilities and pharmacies, among others (Paragraph 2, Fourth Schedule). With devolution, both the National and County Governments have responsibilities to work towards progressive realization of economic and social rights. The two levels of government though distinct and inter dependent, they are expected to consult and cooperate in undertaking their responsibilities.

Integrating Values and Principles of the Constitution and the Rights Based Approach to service delivery

The Constitution of Kenya 2010 introduces a rights-based approach as an expected standard in governance, development and service delivery in all aspects. The Rights based approach to service delivery requires duty bearers at the national and county level to integrate health as a right in

the health policies and laws, set standards for guiding the delivery of health services, and integrate the constitutional values of equality and non discrimination, public participation and people centred approaches to planning and programming, transparency and accountability in service delivery.

A rights-based approach to health service provision and management requires the rationale, methods and approaches used in service delivery emanate from an understanding of human rights and human dignity and ultimately contribute to outcomes that can be articulated within the Kenya Bill of Rights and international human rights standards. It requires a proactive rather than a passive approach by service providers. It calls for service provision that is mindful of those who have poor or no access; those who for various reasons may be ignored or excluded; those who are at risk; among other factors. A rights-based approach to health service delivery in Kenya would need to address questions of non-discrimination, physical access, affordability, adequacy, information, privacy and acceptability (mindful of diversity and human dignity)[4]. Incorporating both the practice and culture of institutional accountability for protecting human rights is essential to avoid shifting responsibility solely onto the service providers. Health and development policies all have a role to play in ensuring a rights based approach to health services delivery is possible.

Elements of the Rights-Based Approach

The project focused on the four essential elements of the rights-based approach in healthcare services, namely:

i. Availability
ii. Accessibility
iii. Acceptability
iv. Quality

The following table provides a breakdown of the elements and the associated principles that were key in this study.

4 See Comment 12, United Nations Committee on Economic, Social and Cultural Rights, "General Comment No. 14 on the Right to the Highest Attainable Standard of Health," E/C.12/2000/4, Geneva: United Nations (2000)

	Element	Associate Principles
1	**Availability**	• Availability & sufficiency of functioning healthcare facilities (Equity, social justice, inclusiveness, equality) • Availability & sufficiency of supplies and equipment • Availability & sufficiency of staff
2	**Accessibility**	• Physical (geographic) access: means of access; physical barriers to access; distance; time taken to access • Organizational access: arrangement of healthcare services and programmes; signage; waiting time; hours of operation; non-discrimination, inclusiveness and protection of the marginalized • Economic access: direct & indirect costs of healthcare services • Access to information: client consultation & counselling; information, education and communication
3	**Acceptability**	• Privacy & confidentiality • Culturally appropriate, respectful of individuality and human dignity • Promoting freedom of expression and informed choice
4	**Quality**	• Availability of safe and potable water • Adequate sanitation: Clean and healthy environment • Perspectives on quality (client and staff) • Participation, feedback and accountability measures • Service Charters

1.2 Statement Problem

Prior to the promulgation of the Constitution on 27th August 2010, the health sector was plagued by a myriad of challenges including mismatch between the health sector strategies and the implementation record, meagre investment and funding, poor services particularly in the public health facilities, lack of services in rural and marginalised regions, drug stock outs, demoralised professionals and staff who are not properly facilitated to deliver their duties. The Constitution of Kenya brought about fundamental reforms to the health sector by the recognition of health as a fundamental human right. Despite it elevated status, numerous reports started showing up with the media on malpractices in the health sector. For instance, there have been reports of many Kenyans who cannot access or afford the health facilities and for those having access, the service provided is not of the requisite quality as per the required international standards guaranteed under international human rights instruments with such persons being perceived as beneficiaries of charity and not active participants of the service delivery process and determination of interventions.

The Constitution through Article 10 provides for values and principles that the two levels of government and the service providers must consider in service delivery. Although these values and principles bind all persons, they are yet to be implemented in health facilities at both levels of government. With the health service delivery being devolved, the County governments can define how they will deliver health care services to the standards provided by the Constitution. CIC, acting on its facilitative mandate has partnered with the county government of Kitui to undertake this project as one of the first steps toward the full implementation of the Constitution by the county of Kitui in so far as health as a devolved function is concerned and integrating right based approach into administrative and operational frameworks in health facilities to provide a better system for health service delivery.

Importantly, the project arises during a period of transition to a fully devolved health system. There have been challenges in the transition and project was undertaken with the consciousness that the current county structures and systems of health services delivery are primarily a template of the pre-devolution national health management strategies. The efforts to decentralize healthcare were already a priority for the national government before the more decisive shift to devolution. Devolution has introduced some changes at county levels and continues to do so. However, a number of the challenges and opportunities within the county health sectors emanate from the previous structures, programs and management systems. Under devolved management of healthcare, these opportunities and challenges continue to fluctuate as counties also take control of their respective health sectors. This project remained conscious of these realities in undertaking the assessment of the current health services delivery efforts at county level.

The review examined the administrative frameworks, the service delivery culture and processes, and the service charters of facilities in the Counties. It drew from client and staff experiences and perceptions to assess the actual engagement with the health sector and what opportunities and gaps emerge. The study was timely and strategic, given the transitional period in devolution of health services and the constitutional mandate of a rights-based approach.

1.3 Project Objectives

The main objective of this project was to review the operational frameworks of county health facilities against the Constitution, evaluate their strengths and weaknesses and make recommendations on how the county can integrate the values and principles of the Constitution in its health facility services.

The specific objectives were to:

a. To audit the county health facility service charters against the Constitution and review them to align them with the constitution.
b. To audit the county health facility operational frameworks including the policies, regulations and guidelines, management tools and service delivery culture and make recommendations on how the county can improve on them and integrate the values of constitution and rights based approach to service health delivery.
c. To develop the capacities of the County health sector teams on the right to health in the constitution and the implementation of Article 10 and the rights based approach to service delivery.
d. To develop a documentary on the project process as a way of guiding any other county or stakeholder that might want to undertake a similar process.

1.4 Kitui County Profile

Map illustrating Kitui County Location within Kenya

Source: *Health Sector Human Resources Strategy, 2014-2015*

Kitui County covers an area of 30,429 square kilometres, and has an estimated population of 1,012,709 according to 2013 data of the Commission for Revenue Allocation (CRA).[5] Poverty is rife and affects livelihood, nutrition and health levels. The majority of the population is employed in agricultural activities, with limited opportunities in commercial ventures and public service.[6] The CRA estimates that nearly 47% of the population is under the age of 15 while males represent 48% of the population and females 52%. The County is diverse with some areas being semi-arid and dry, while other parts are fairly arable. Water scarcity remains a challenge.

5 See www.crakenya.org/county/kitui/

6 Population Action International, "Population Dymanics and Sustainable Development in Kitui County," July 2014, p.2. Available at http://populationaction.org/wp-content/uploads/2014/07/PAI_Kitui.pdf

Administratively, the County is divided into 16 sub-counties.[7] For delivery of health services, the sub-counties have been re-grouped into eight sub-counties, namely:

- Kitui Central,
- Kitui Rural,
- Kitui South,
- Kitui East,
- Kitui West,
- Mwingi Central,
- Mwingi North ,
- Mwingi West.

For consistency, the study uses the health sector regrouping when referring to the sub-counties. The County Ministry of Health and Sanitation is organized into key service departments including, clinical, nursing, diagnostics, rehabilitative, pharmaceutical, public health, nutritive and ambulance services, among others.[8] There are approximately 1,086 health workers involved in health service delivery in 225 health facilities; 11 hospitals, 31 health centres, and 183 dispensaries[9].

Based on national health facilities classification into levels, Kitui health service delivery is organized as follows:

- Level 1 – delivery of community-level health promotion, hygiene, and sanitation through community strategies.
- Level 2: – dispensaries for the provision of health promotion, curative, preventive, ambulance, HIV and TB, and maternal and child health services.
- Level 3 – health centres for the provision of health promotion, curative, preventive, ambulance, HIV and TB, and maternal and child health services, and
- Level 4 – the sub-County and County hospitals where facilities exist for provision of more specialized services such as surgical, dental and ophthalmology services, psychiatric care, physiotherapy, occupational therapy, orthopaedic therapy, specialized paediatric, radiology, obstetric and gynaecological services and ambulance services. These are the County's Level V facilities.

All levels of health service delivery in Kitui County were included in the project study and review.

7 Administratively, Kitui sub-counties are, Kitui Central, Lower Yatta, Kitui West, Kisasi, Nzambani, Mutitu, Mutomo, Ikutha, Katulani, Matinyani, Mwingi Central, Mwingi East,Tseikuru, Muumoni, Kyuso and Migwani

8 See http://www.kitui.go.ke/index.php/ministries/ministry-of-health-and-sanitation

9 See http://www.kitui.go.ke/index.php/ministries/ministry-of-health-and-sanitation

1.5 Methodology of the RBA in Health Services Project

1.5.1 Study Design

The project utilized a participatory and capacity building approach whereby rights based and public health consultants worked in consultation with national and county health teams to review the current operational frameworks for service delivery in county health facilities and use the information collected to integrate the values and principles of the Constitution and the rights based approach into their service charters. Background data on health service delivery was collected through a cross sectional survey using quantitative and qualitative methods.

The specific tasks undertaken included:

- Reviewing and identifying any inconsistencies of the frameworks in relation to the Constitution of Kenya 2010 and the constitutional values and principles including the Rights Based Approach to service delivery;
- Reviewing the current frameworks against the health related provisions in international treaties ratified by Kenya;
- Preparing and making of presentations for capacity building and project information for the stakeholder forums;
- Making recommendations for the delineation and inclusion of key human rights-based indicators relevant to the right to health and integration them in the determined tools for the delivery of the products for the project;
- Ensuring inclusion of vulnerable and marginalized population including women, children and older persons;
- Preparing and presenting progress reports on various activities; and
- Drafting the final facility charters for the county health facilities and the final project report and contributing to the overall project report.

1.5.2 Scope

The study was carried out in eight (8) sub counties of Kitui, namely, Kitui Central, Kitui Rural, Kitui West, Kitui East, Kitui South, Mwingi Central, Mwingi West and Mwingi North.

Health Facility Levels

The project targeted the four levels of County health services within Kitui (Kenya Health Policy 2014-2030); Level 1 (Community), Level 2

(Dispensaries), Level 3 (Health centres), and Level 4 (District and sub-district hospitals). The table below summarizes the distribution of health facilities within Kitui County[10].

Sub-county	Hospitals	Health Centres	Dispensaries	Total
Kitui Central	2	1	33	36
Kitui Rural	1	3	22	26
Kitui West	1	0	18	19
Kitui East	1	3	19	23
Kitui South	1	10	19	30
Mwingi Central	2	8	25	35
Mwingi West	1	5	27	33
Mwingi North	2	6	20	28
Total	**11**	**36**	**183**	**230**

A total of 48 facilities (20.89%) were selected for inclusion in the project – 6 health facilities from each sub-county. This included all the 11 hospitals, 16 health centres, and 21 dispensaries. Generally, at least one health facility was selected from each Ward in the eight sub-counties.[11] Appendix 1 contains the health facilities from which data was collected in Kitui County, categorized by Sub-county and Ward.

The table below summarizes the distribution of health facilities selected for inclusion in the study by sub-county and facility level.

Sub-county	Hospitals	Health Centres	Dispensaries	Total
Kitui Central	2	1	3	6
Kitui Rural	1	2	3	6
Kitui West	1	0	5	6
Kitui East	1	2	3	6
Kitui South	1	3	2	6
Mwingi Central	2	2	2	6
Mwingi West	1	3	2	6
Mwingi North	2	3	1	6
Total	**11**	**16**	**21**	**48**

10 Source: Kitui County Health Records and Information Management Office, March 2015

11 One of the Wards, Endau/Malalani in Kitui East was not included in the study due to security concerns

1.5.2 Data Collection

Data was collected using a variety of methods, including document reviews, client exit interviews, staff interviews, facility in-charge interviews, facility observation, focus group discussions, and key informant interviews.

The tools used to gather data include:

- *Client exit questionnaire* to interview clients who had used the health facilities before they exited the premises. These allowed for a large number of clients to be sampled in order to gather views from diverse population groups. In total, 362 clients were interviewed.
- *Health facility staff questionnaire* to interview all cadres of health care workers, which provided a standard set of assessment parameters for the staff at all facilities.
- *Health facility observation* to collect data both at the inpatient and the outpatient departments by observation. A total of 48 health facilities were observed using a facility observation guide;
- *Focus group discussions* conducted within the vicinity of the health facility among general community members. These were useful in assessing general perceptions and opinions, which allowed for comparison with the data collected in the client interviews. A total of 10 focus group discussions and interviews (86 respondents) were conducted with representatives from various sections of the community. These discussions drew representation from persons with disability (visual, physical and hearing), men, community health workers (CHWs), persons living with HIV (PLHIV), antenatal clinic (ANC) clients, women seeking outpatient services, young mothers, and youth.
- *Key informants interview (facility and county level)* administered to representatives of civil society, media, county and national government representatives to obtain specific management, policy and administrative information. A total of 33 interviews were conducted with key informants from various health facilities across the County, and 3 interviews were conducted with sub-county and county representatives. Three interviews were also conducted with a civil society organization, a CIC Commissioner, and national health department official.
- *Document review* of reports, literature, research studies and secondary data. 18 operational frameworks were reviewed – 2 from the County level and the rest from the National level (the list of the operational frameworks reviewed is included as part of Appendix 8). The findings from the operational frameworks reviewed are included as Appendix 11-1 to Appendix 11-18.

A total of 615 individuals were interviewed for the study.

Respondent Category	Number
County Health Ministry officials	3
Health Facility Managers (key informant interviews)	33
Medical personnel (survey/interview)	128
Clients (users of facilities)	362
Community members (through Focus Group Discussions)	86
Other key informants	3
Total	**615**

The table below summarizes the data collected using the different methods within the County.

Sub-county	Clients	Staff	FO	KIIs	FGDs
	362	**128**	**48**	**36**	**10**
Kitui Central	46	17	6	9	5
Kitui East	46	17	6	4	
Kitui Rural	43	14	6	4	
Kitui South	50	21	6	3	
Kitui West	34	9	6	6	
Mwingi Central	50	15	6	3	4
Mwingi North	43	20	6	4	1
Mwingi West	50	15	6	3	

FO: Facility Observation KIIs: Key Informant Interviews FGDs: Focus Group Discussions

All the tools used in data collection were developed specifically for the study. The data collection tools were selected to facilitate triangulation of the data. Individual perceptions and opinions were assessed against situational observations and ongoing service delivery activities. The triangulation allowed for identification, resolution and/or elucidation of contradictions as well as noting where data was verified across the several different respondent groups.

Data collection at the facilities was done with the support of data collectors from the County, identified by CIC and the County Oversight teams. The consultants also carried out direct interviews with key informants and facilitated focus group discussions. The data collectors were equipped with phones preloaded with electronic versions of the questionnaires. This system not only allowed for real-time uploading of the data as it was

collected, but also ensured the data was kept private and safe after collection to limit possibility of accidental or deliberate tampering with the data. It also provided immediate backup of the data, minimizing the dangers of lost data, which was a possibility, given the volume of data being collected and number of data collectors. Using Open Data Kit, the study questions were coded and administered electronically on phone. The Open Data Kit was backed by GPS tracking of phones to provide electronic mapping and confirmation of the sites that were visited.

Key informant interviews and focus group discussions were recorded on voice recorders and transcribed. Photos were taken of facilities, charters, and other areas of interest identified in the facility observation guides. As part of documenting the entire process, the Commission for the Implementation of the Constitution also facilitated video recording of planning and data collection processes. A media expert was hired to coordinate the video filming and interviews. The research team ensured that video recording did not interfere with sensitive data collection sessions. Participant consent was sought prior to each video recording to include only respondents who were informed and willing to participate in the video documentation. Consent to Photograph, Video or Record Form was used to obtain permission from persons who were either photographed and/or videotaped. The consent form is included as Appendix 9.

1.5.3 Profile of Interview Respondents

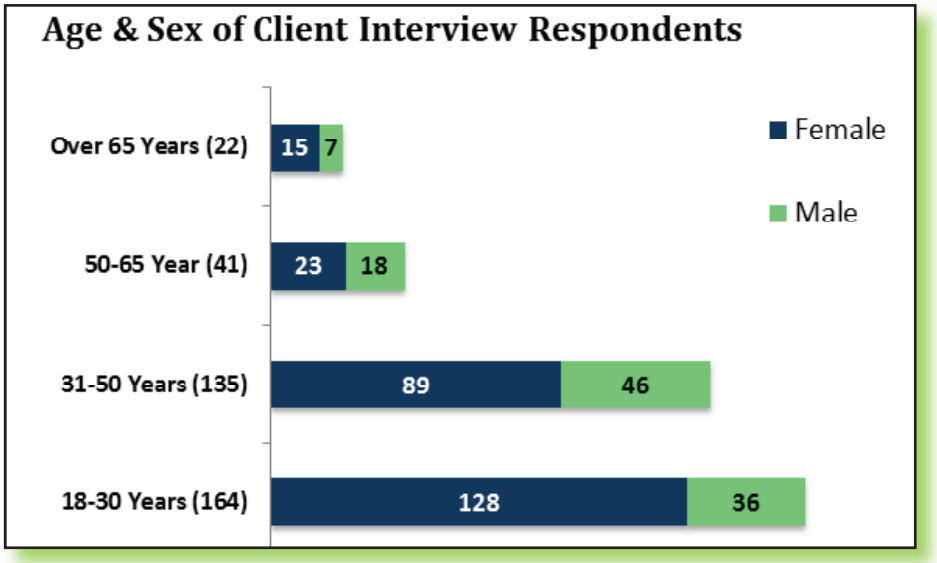
Client Interviews

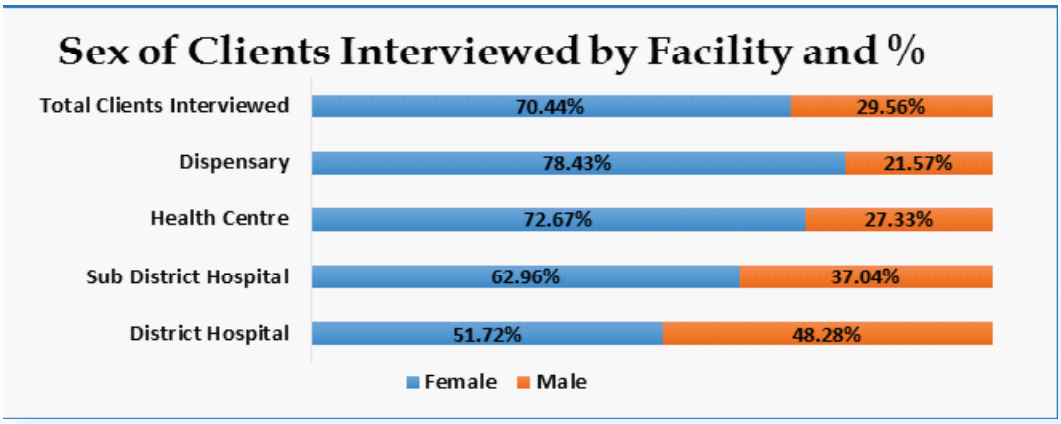
A total of 362 interviews with clients from 47 facilities[12] were conducted county-wide and from the different health facility levels (dispensaries, health centres, and hospitals). Of the 362 clients interviewed, slightly over 70% of them were females. Most of those interviewed at the health facilities were aged 18-30 (45.3%) while only 6%were over 65. Majority of the clients interviewed (41.4%) were visiting health centres, 28.2% were at dispensaries, 22.4% at sub-district hospitals, and the remaining 8% were at district hospitals.

Profile of Respondents – Client Interviews

Age Bracket	Male	Female	Total
18-30 Years	128	36	164
31-50 Years	89	46	135
51- 65 Years	23	18	41
Over 65 Years	15	7	22
Total	**255**	**107**	**362**

12 In one of the facilities (Muselele Dispensary, Kitui East), there were no clients to be interviewed as the facility had been closed for a while since the only clinical staff was away on leave.

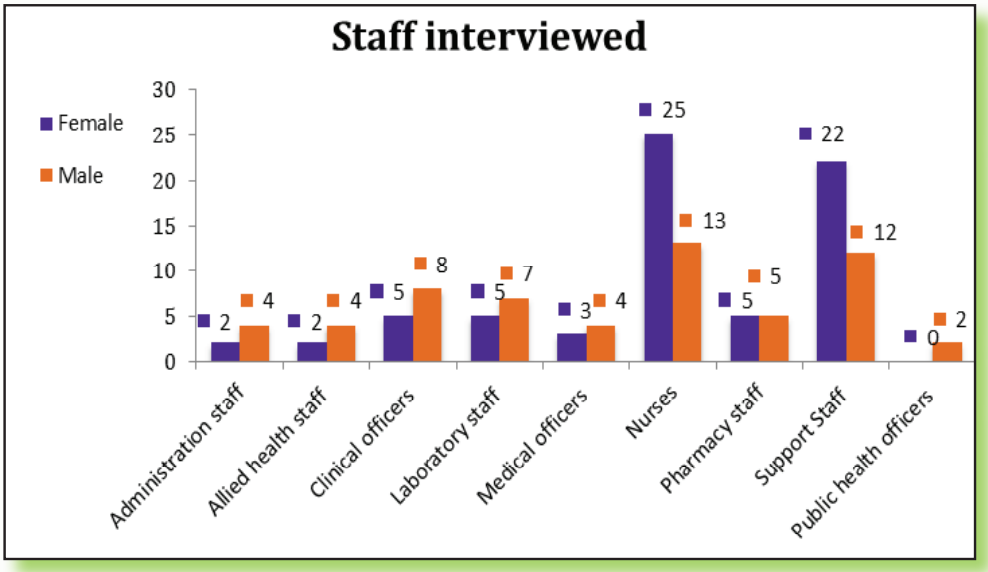


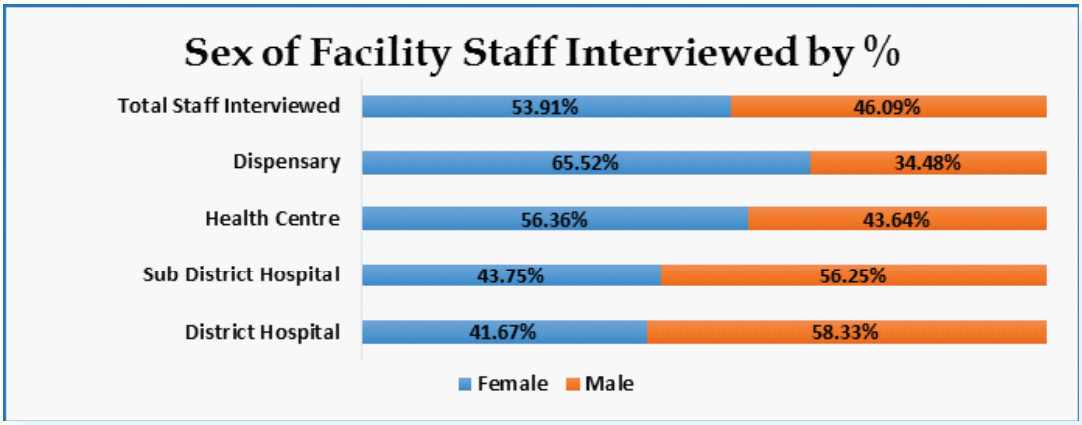


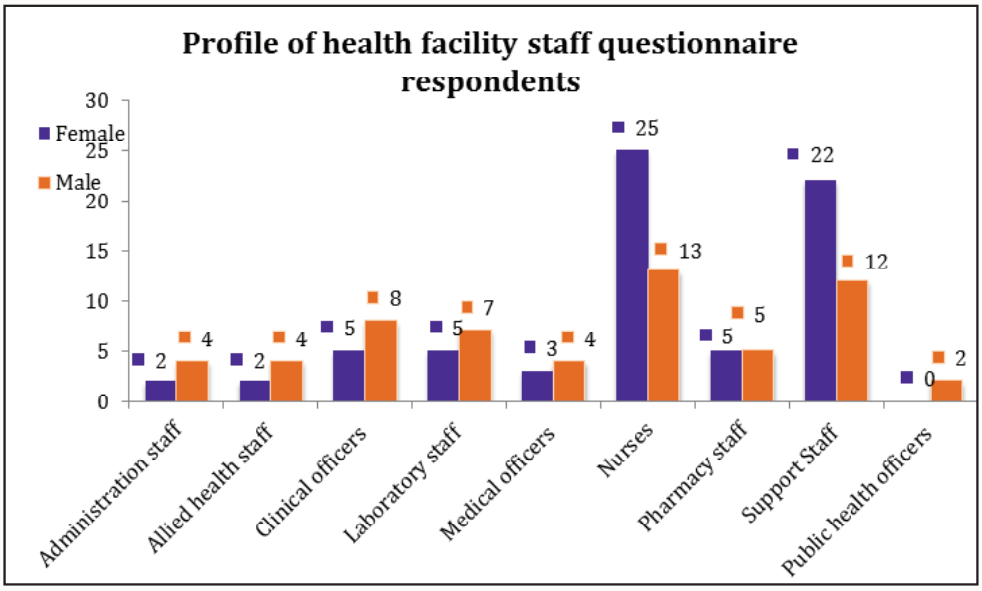
12 of the clients interviewed (3.3%) had a disability; 6 had a physical disability, 3 had a visual impairment, 1 had a hearing impairment, 1 an intellectual impairment, and 1 had both a physical and intellectual impairment.

Health Facility Staff Interviews

A total of 128 interviews were conducted with staff from each of the participating health facilities. Of the 128 health facility staff interviewed, 53.9% of them were females. Majority of the staff (43%) worked at health centres, 25% at sub-district hospitals, 23% at dispensaries, and 9% at district hospitals. About 30% of the staff were nurses, 27% were support staff, 10% were clinical officers, 9% laboratory staff, 8% pharmacy staff, 6% were medical officers, and 11.7% were from various other cadres.


Staff interviewed
Female
Male
30
25
20
15
10
5
0
2
4
2
4
5
8
5
7
3
4
25
13
5
5
22
12
0
2
Administration staff
Allied health staff
Clinical officers
Laboratory staff
Medical officers
Nurses
Pharmacy staff
Support Staff
Public health officers


Sex of Facility Staff Interviewed by %
Total Staff Interviewed
53.91%
46.09%
Dispensary
65.52%
34.48%
Health Centre
56.36%
43.64%
Sub District Hospital
43.75%
56.25%
District Hospital
41.67%
58.33%
Female
Male


Profile of health facility staff questionnaire respondents
Female
Male
30
25
20
15
10
5
0
2
4
2
4
5
8
5
7
3
4
25
13
5
5
22
12
0
2
Administration staff
Allied health staff
Clinical officers
Laboratory staff
Medical officers
Nurses
Pharmacy staff
Support Staff
Public health officers

1.5.4 Data Analysis

The data was analyzed using Statistical Package for Social Sciences (SPSS) software and Microsoft Excel data analysis tools. Data collected was pivoted (cross-tabulated) and assessed for specific variables including, frequency distributions and tendencies, among others. Both the quantitative and qualitative data were individually analyzed as well as cross-analyzed to provide a holistic picture of what the data was actually saying. The findings were clustered and analyzed to determine how they responded to the four elements of a rights-based approach: availability, accessibility, acceptability and quality.

1.5.5 Limitations of the Study

- As a scoping and baseline exercise, the study went wide rather than deep. This means while it presents a broad overview of the current situation, it does not delve deeper into responses given to establish deeper meanings, causal factors, nuances and iterations. As a scoping study it highlights the areas that would then be the subject of a causal analysis.
- Facility observation tools are useful in providing fairly objective and in-progress assessments of the facilities. However, they cannot be entirely free from the biases of the persons observing, as they are required to make a judgement call on the meaning of what they observe. The study overcomes some of the biases that may arise by cross triangulating data with the different data collection methods (focus group discussions, individual interviews and survey).

2.0 Legal and Policy Frameworks

2.1 Background

Health care service delivery in Kenya under the current constitutional dispensation is expected to promote the realization of the highest attainable health for individuals.[13] The Constitution provides a broad legal framework for the values and principles of public service delivery, which bind service providers within the public health sector. These include:

a. High standards of professional ethics
b. Efficient, effective and economic use of resources
c. Responsible, prompt, effective, impartial and equitable provision of services
d. Involvement of the people in the process of policy making
e. Accountability for administrative acts
f. Transparency and provision to the public of timely, accurate, information
g. Fair competition and merit as the basis of appointments and promotions
h. Representation of Kenya's diverse communities and
i. Affording adequate and equal opportunities for appointment, training and advancement of all levels of public service for men and women, members of all ethnic groups and persons with disabilities.

In addition, Kenya has included specific legal protections and obligations in order to ensure measures are taken to facilitate the realization of rights for marginalized groups and disadvantaged populations. Every child has the right to basic nutrition, shelter and healthcare (Article 53). Persons with disabilities must be treated with dignity and respect and should be addressed and referred to in a manner that is not demeaning. Further, public facilities are expected to ensure persons with disabilities can gain access to the facilities (Article 54). Minorities and marginalized groups are entitled to benefit from measures to ensure they have access to healthcare services.

13 Article 43, Constitution of Kenya

2.2 International Framework

The right to health is guaranteed under most international conventions. Primarily, the International Covenant on Economic, Social and Cultural Rights of 1976 declares the right to the highest attainable standard of physical and mental health as a right that must be protected by states (Article 12 of the Covenant). The right is guaranteed in other international conventions including, the Universal Declaration of Human Rights, the Convention on the Elimination of All forms of Discrimination Against Women, the Convention on the Rights of the Child, among others. Regionally, there is the African Charter on Human and People's Rights; the African Charter on the Rights and Welfare of the Child; and the Maputo Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa.

The guarantee of the right to health internationally is intended to ensure that states take specific measures, relevant to their national contexts, to ensure individuals and populations enjoy the highest attainable standard of health. Kenya has been acceded to the Covenant on Economic Social and Cultural Rights in May 1972, and further, the Constitution of Kenya 2010 states that international laws that Kenya has signed and ratified are automatically part and parcel of Kenyan law.[14]

2.3 Kenya Policy Framework on a Rights-Based Approach to Health Services Delivery

Prior to the new Constitution, the legal and policy frameworks for delivery of healthcare were robust, progressive and responsive to the realities of the country in providing a guide for addressing the healthcare needs of different population groups. Kenya Vision 2030 developed in 2006 identified the realization of the right to health as an essential prerequisite to realizing the nation's development vision by 2030. The policy blueprint identifies a *"high quality affordable health care system" and preventive care at "community and household level, through a decentralized national health-care system"* as the priority actions for leading the country forward in the health sector.

The National Health Sector Strategic Plan I (1999 – 2004) as the first national sector-wide health strategy, pointed out the need to decentralize health services delivery and management as well as focusing on preventive interventions as among the leading strategies towards improving health indicators. The first Strategic Plan preceded the guiding note provided in

14 Article 2(6), Constitution of Kenya 2010

General Comment No. 14 of the UN Committee on Economic Social and Cultural Rights. Nonetheless, it incorporated important elements of the right to health, including prioritizing quality, accessibility and affordability of healthcare for the entire population. Notably, by the second plan, the National Health Sector Strategic Plan II 2005 – 2010, Kenya had seen significant reversals in nearly all key health indicators.[15]

Policy Framework after the New Constitution

The Kenya Health Policy 2012 – 2030 aligned the health sector firmly with Kenya Vision 2030 as well as with the Constitution. It incorporated the changes introduced by the Constitution including the anticipated full devolution of health services, and recognized the place of the right to health in Kenya's economic aspirations and development. The language of the Health Policy 2030 is clear on employing a rights-based approach in health services delivery. It envisages that a rights-based approach entails integrating

> "human rights norms and principles in the design, implementation, monitoring, and evaluation of health interventions and programs. These include human dignity, attention to the needs and rights of vulnerable groups, and an emphasis on ensuring that health systems are made accessible to all."

The policy also demonstrates a consciousness of the value of people-centred, participatory, equitable and multi-sectoral approaches to health and health services delivery as the way to realize the highest attainable standard of health for people in Kenya. The Health Policy 2012-2030 goes on to provide a policy orientation which delineates the approaches needed to realize the objectives of the policy. This introduces progressive thinking in making policy more implementable. The policy orientation requirements highlight the leadership, governance and management of the health sector; the workforce needed to realize the goals of the health sector; the infrastructure needed to deliver health services, among others.

Towards a Rights-Based Approach in Health Service Delivery

In view of the new constitutional dispensation and the developing global and national practices on medical care, the Ministry of Health developed

15 See generally, Central Bureau of Statistics (CBS) [Kenya], Ministry of Health (MOH) [Kenya], and ORC Macro. 2004. Kenya Demographic and Health Survey 2003. Maryland: CBS, MOH, and ORC Macro. See also National Health Sector Strategic Plan II 2005 - 2010

the Kenya National Patients' Rights Charter in 2013, which provided a simple but comprehensive set of patients' rights and responsibilities within the health services delivery system. The Rights Charter identifies as its rationale the fact that the right to health is now a constitutional right and the standards, values and principles of public service are binding to all state organs and public officers. As such, through the Rights Charter, the Ministry is providing a framework and direction on service delivery to actualize this right.

The Kenya Sector Strategic and Investment Plan 2014 – 2018 draws from the Health Policy 2012-2030 and the second National Health Sector Strategic Plan 2005-2010 to expound on the health sector objectives, the commitment to a rights-based approach to health services delivery and the coordination structure between the County and National Governments. In particular, it prioritizes access to health care as a goal of the health services delivery in the Kenya context. It analyses the impediments to access and notes that non-affordability of services and socio-cultural beliefs present prominent barriers for people in Kenya in gaining access to healthcare. Quality healthcare service delivery is identified as a desired output and the Plan recognizes that quality is progressive and must be realized within the available resources and improved over time. Further, the important action points for Kenya in improving quality of healthcare include:

- Improving services relevance and acceptability by use of regular service charters and conducting regular client satisfaction surveys to continually ensure clients expectations are informing interventions;
- Improving continuity of care through strengthening of referral services, and improving patient experiences in utilization of services; and
- Ensuring a comprehensive approach to services is applied and used, not focusing only on programs backed by a strong monitoring and evaluation framework, among others.

The health sector has gone on to develop issue-specific and population specific health policies to address problematic issues that may not be adequately attended to by general policies, to draw attention to particular disadvantaged, marginalized or minority groups among others. Some of these include, Kenya Health Sector Referral Strategy 2014-2018 and Referral Implementation Guidelines 2014; National Guidelines for HIV/ STI Programs with Key Populations, 2014; Community Strategy – Taking the Kenya Essential Package of Health to the Community; Community Strategy Implementation Guide; Standards for Peer-Education and Outreach Programs for Sex Workers 2010; among others.

These policies are in keeping with a rights-based approach to health service delivery and the commitments in Kenya Vision 2030 and Kenya Health Policy 2012-2030. They identify specific focus areas and provide policy guidance on improving services and access for the affected populations. The Kenya Health Policy 2012-2030 emphasizes the attention to the needs and rights of vulnerable groups with the aim of ensure that health systems are made accessible to all.

From policy to practice

Studies point out that Kenya's health policy framework is strong and provides context-relevant direction that focuses on raising the standard of healthcare in the country.[16] However, a persistent challenge remains in implementing policies effectively. The National Health Sector Strategic Plan II (2005-2010) notes that the overall implementation of the first Strategic Plan did not make a breakthrough in transforming the critical health sector interventions or meeting the most significant targets and indicators of health. As a result, Kenya experienced a reversal of nearly all the key health indicators. Under second Strategic Plan, the emphasis was on primary healthcare but the resource investment was most significant in secondary and tertiary care that provide for curative and specialized services.

At the same time, Kenya is yet to meet the commitment of 15% annual budget allocation to health services that heads of state of the Africa Union made in 2001 (the Abuja Declaration)[17] towards improving the health sector. Like other sectors, the health sector policies have also faltered on implementation due to the political contestations and influences that from time to time overshadow the technical implementation of policies on health.

There have been important gains, such as reductions in maternal and infant mortality, reduction in HIV infection rates, among others. But collectively, the health sector policies while robust, are greatly impeded in enabling the technocrats and the service providers from edging Kenya forward at a steady pace on realizing the health targets and indicators. Implementation of the policies requires further thought, action, consistency and goodwill across the Board.

16 See, Glenngård Anna H. 2005. Policies in the Kenyan Healthcare Sector – Why are they so difficult to implement? SIDA 2005 p 3-5; and Mohajan, H. K. (2014). Improvement of Health Sector in Kenya. American Journal of Public Health Research, 2(4), 159-169

17 Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases 2001. The Abuja Declarations are a series of declarations on health in Africa.

2.4 Kitui County Legal and Policy Framework

The Kitui County Integrated Development Plan 2013-2017

The Kitui County Integrated Development Plan 2013-2017 provides the blueprint for the overall County development agenda. The mission of the County Ministry of Health is to ensure accessible, affordable and quality health care to all its residents. This already incorporates an awareness of the key elements of the right to the highest attainable standard of health. It prioritizes mobile clinics and health wagons to reach populations who do not have easy access due to infrastructural challenges.

Among the ongoing projects and programs identified as at the time of developing the Plan, none of the 10 initiatives were for primary or preventive healthcare services. Most focused on secondary and tertiary intervention levels and internal staff capacity and motivation. All the initiatives are necessary for a strong healthcare system, however, a rights-based approach would require prioritization based on the situation and needs of the population. The Plan indicates a shift in planning and identifies the flagship programmes during the implementation period as (1) upgrading of Kitui and Mwingi Hospitals to Level V status; (2) a Maternity unit and theatre development programme; and (3) a primary healthcare programme. The Plan also identifies several stalled projects, many of which are the construction of dispensaries and health centres. The Plan is fairly abbreviated in providing direction and would require further development through specific Kitui Health Ministry policy, law and strategic plans. As at the time of the study, no specific health policy or legislation was available.

Health Facilities Management Committees Bill 2014

Kitui County also has the County Health Facilities Management Bill drafted in 2014. The Bill is part of the county's compliance with the health management structure developed after the Constitution of Kenya 2010 and as part of the devolved system of health service management. The Bill is expected to provide for a facilities management committee that provides an avenue for consultative engagement in prioritizing health service delivery across the County. In addition to providing quality management, facility oversight, finance management and audit oversight, the committee is expected to oversee and advise on access, availability, affordability and related factors.

The current draft Bill gives the Governor responsibility to appoint all nine members of the committee although she or he must receive nominations from the county assembly for the positions. Among the membership, there must be a person with knowledge of finance and administration, nominees from women's groups, faith-based groups, youth groups and persons with disability.

While the Bill seeks to be progressive in the membership of the committee and the functions in relation to health services delivery, it also has inherent challenges presented by the nomination and appointment structures that would require further review to ensure adequate checks and balances. The Bill would also benefit from an overarching Kitui Health Sector law and policy, which provide the framework within which the committee would operate. As such, the County needs to bolster its law and policy development strategies as well as implementation strategies.

3.0 Findings and Discussion

The Constitution of Kenya 2010 encapsulates the imperative for implementing a rights-based approach in healthcare provision. Article 10 requires all public officers to apply the principles of the Constitution, which include among others, respecting human dignity, equity, social justice, inclusiveness, equality, human rights, non-discrimination and protection of the marginalised. In the Bill of Rights in Chapter Four, Article 43 specifically protects

> "the right to… the highest attainable standard of health, which includes the right to healthcare services, including reproductive healthcare ."

The process of devolution has brought opportunity to expand, diversify and intensify healthcare for health equity at local levels; greater than was previously possible or undertaken. The findings from all the tools administered in the study are discussed below according to the four elements that define the implementation of a rights-based approach in health care. All the elements are in fact interconnected with developments in one aspect affecting all the other aspects.

3.1. Availability

The aspect of availability in the rights-based approach to healthcare seeks to ensure that the quantity and distribution of public health care facilities and services are adequate for a population and distributed equitably.

3.1.1 Health Facilities (Service Delivery Units)

The Ministry of Health Norms and Standards for Health Service Delivery recommend that every 5,000 persons should be served by Level 1 health services (Community Unit); every 10,000 persons by Level 2 health services; every 25,000 persons by Level 3 health services; and every 100,000 persons by Level 4 health services. Kitui County has 11 hospitals, 36 health centres, and 183 Dispensaries against the minimum recommended of 10, 41, and 101 respectively.

Based on the Norms, the number of health facilities available in Kitui County appears to be mostly adequate (see the table below). However, a Ward level analysis (Appendix 12) of the distribution of health facilities indicates that some of the Wards are underserved by health facilities especially at the health centre level (assumed to be synonymous with level 3 health services).

Comparison of Available and Recommended Numbers of Service Delivery Units

Sub-county	Population	Hospitals		H. Centres		Dispensaries		CUs	
		CN	RN	CN	RN	CN	RN	CN	RN
Kitui Central	131,715	2	1.32	1	5.27	33	13.17		
Kitui Rural	104,443	1	1.04	3	4.18	22	10.44		
Kitui West	102,314	1	1.02	0	4.09	18	10.23		
Kitui East	123,239	1	1.23	3	4.93	19	12.32		
Kitui South	166,050	1	1.66	10	6.64	19	16.61		
Mwingi Central	141,207	2	1.41	8	5.65	25	14.12		
Mwingi West	103,774	1	1.04	5	4.15	27	10.38		
Mwingi North	139,967	2	1.40	6	5.60	20	14.00		
TOTAL	**1,012,709**	**11**	**10.12**	**36**	**40.51**	**183**	**101.27**	**80**	**202.5**

KEY: **CN: Current number** **RN: Recommended number** **CUs: Community Units**

Level 1 (Community) services form the foundation of the health delivery system. At this level, a network of Community Health Workers (CHWs) is expected to visit about 25 households each month to provide health education, perform monitoring of some key indicators, and generally contribute towards the improvement of preventive and promotive behaviours among the community members. Based on the Norms, Kitui County should have about 203 Community Units. The County currently has 80 Community Units, most of which were established with support from development partners. This study was not able to establish whether the existing Community Units are fully functional. However, discussions with some Community Health Workers from Mwingi Central seem to indicate that the CHWs are no longer willing to perform their duties for free and without any form of facilitation (they are expected to deliver reports to their supervisors and are not provided any transport reimbursement to move around as they perform their duties).

"Sisi tunatoka mbali sana na kwenda households 70 ni ngumu sana. Tungepata means za kwenda - baiskeli, motorbikes - tungekuwa tunaendelea tu vizuri, kwa vile 50 households ni mingi sana. Wacha sasa hiyo ya kuwa mingi sasa, kitambo nitoke huko nije huku, hapa kuna mtu ametumia pesa mingi sana karibu shilingi mia tatu, kitambo akuje hapa, na kama angekuwa na piki piki angefika ile masaa unataka. Huyu daktari tunamletea hapa naye anatwambia saa tatu tuwe tumefika hapa tumletee feedback. Saa inatubidi utoke huko ukuje na means yako."

Community Health Workers, Mwingi Central

Translation:

"We come from far and visiting 70 households is very difficult. If we could be given means to move around – bicycle, motorbike – that would help, as 50 households are many. Apart from being many, by the time you move from the community to come here (Waita, where the supervisor is), there is someone here who has spent about three hundred shillings. If you had a motorbike, you would have arrived at the expected time. This doctor that we bring the report asks us to be here by 9 am. It forces us to use our own means to get here."

Community Health Workers, Mwingi Central

It also emerged that some of the CHWs have stopped performing their duties, and the remaining CHWs are now responsible for between 40 and 70 households each (against the recommended 25 households). This puts a major strain on the ability of the CHWs to function effectively. The CHWs prioritize their work by ensuring that they visit any household that has children below 5 years and expectant women each month to monitor their progress. The County should review the community level services and strengthen them especially in areas where health facilities are not as many as they should be.

Level 2 health services form the first point of referral from the community to the health facilities. Facilities performing level 2 functions offer basic curative, rehabilitative, preventive, and promotive services, including antenatal care, immunization, administration of Vitamin A, under-5 growth development follow-up, family planning, and case management of simple illnesses, among others. Kitui County has 183 compared to the minimum recommended number of 101 facilities performing level 2 functions (assuming Dispensaries are categorized as Level 2).

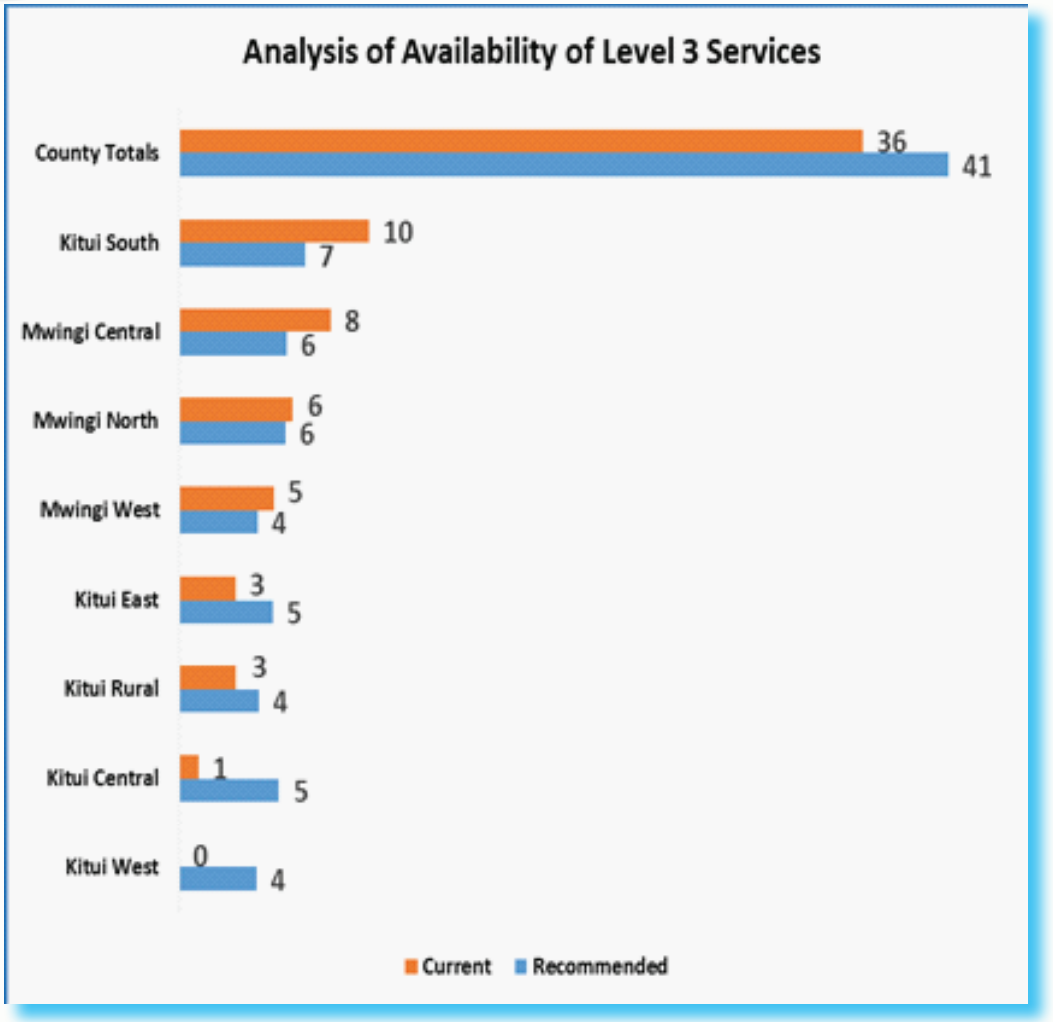
In spite of this high number, Chuluni Ward (Kitui East), Township (Kitui Central), Ikutha (Kitui South), Tharaka (Mwingi West), and Waita/Endui (Mwingi Central) appear to be slightly underserved, and could benefit from the addition of one facility each performing level 2 functions. On the other hand, some of the Wards that are overserved by facilities at this level may need to temporarily close some of these facilities in order to improve the equitable distribution of the facilities as well as optimal functioning of facilities that are open.

Where a Ward (constituency/administrative unit) has more than the recommended number of health facilities performing at a certain level, it puts a strain on the overall County health system's capacity to function at optimally. It may also put the Wards that are underserved at a disadvantage, as they end up having fewer health facilities than they need. When the health facilities are too many compared to the overall resources available, the health system is forced to distribute the resources at a less than optimal ratio to the existing health facilities. For instance, instead of staffing health facilities at Level 2 function with the minimum recommended 2 nurses each, they are staffed with 1 nurse each, which in turn compromises the quality of care that is possible.

Another challenge noted by the staff at Level 2 (and also Level 3) is that there are no staff houses within the health facility. Since dispensaries are only open from 8am to 5pm each weekday and closed at night and on weekends and public holidays, it means that if a client needs services during the times when the facility is closed they are forced to either travel further in search of the services or go to a private facility if available.

Although the number of health facilities performing Level 3 functions appears to be almost adequate (36 against the recommended minimum of 41), a Sub-county and Ward level analysis highlights inequitable distribution of these facilities. This implies that a certain proportion of the population is out of reach of the services that this level of health facilities should be performing. To improve the equitable distribution of health facilities performing level 3 functions, a minimum of 14 facilities at this level should be operationalized: 4 in Kitui Central (Mulango, Kyangwithya West, Kyangwithya East, & Township); 1 in Kitui Rural (Kanyangi); 4 in Kitui West (one in each Ward); 3 in Kitui East (Mutito/Kaliku, Endau/Malalani, and Zombe/Mwitika); 1 in Mwingi Central (Central Ward); and 1 in Mwingi North (Kyuso). An additional one each could also be added in Ikanga/Kyatune (Kitui South) and Mumoni (Mwingi North).

Level 3 facilities should offer maternity services for normal delivery, minor (outpatient) surgeries and specific lab tests (including malaria, smear test for TB, & HIV testing), among other services. Given that this Level is the first opportunity at which clients can receive normal delivery and laboratory services, their distribution needs to be equitable to reduce the distances that clients need to travel to access these services. Alternatively, it is recommended that the capacity of the Level 2 health facilities be improved to be able to perform basic laboratory tests, especially those related to antenatal care (ANC profile) for which the expectant women are normally asked to go to a Health Centre.



Generally, there appears to be an adequate number and equitable distribution of the health facilities that should be performing **Level 4** functions (District & Sub-district hospitals). Facilities performing level 4 functions should be able to offer referral level outpatient care, inpatient services, emergency obstetric care, oral health services, surgery on inpatient basis, client health education, more specialized laboratory tests and radiology services, among others. This study was not able to determine whether each of the health facilities categorized as Level 4 has the resource capacity to perform Level 4 functions. Based on the feedback from the Facility In-charges interviewed, it appears that most of these facilities need to have their facilities and staffing upgraded to enable them perform the Level 4 functions at the minimum recommended level.

A number of the Facility-level key informants indicated that there has been an increase the infrastructural development that is happening now compared to before the devolution of health services. This infrastructural development appears to be happening much more for the Level 4 facilities than for the lower levels.

The County has undertaken an assessment[18] of the number and distribution of health facilities and has prepared a phased plan to address the inequitable distribution of the health facilities that will run from the 2016/2017 to 2019/2020 financial year. This will necessitate the construction of new health facilities in the Wards that have fewer as well as the employment of more staff.

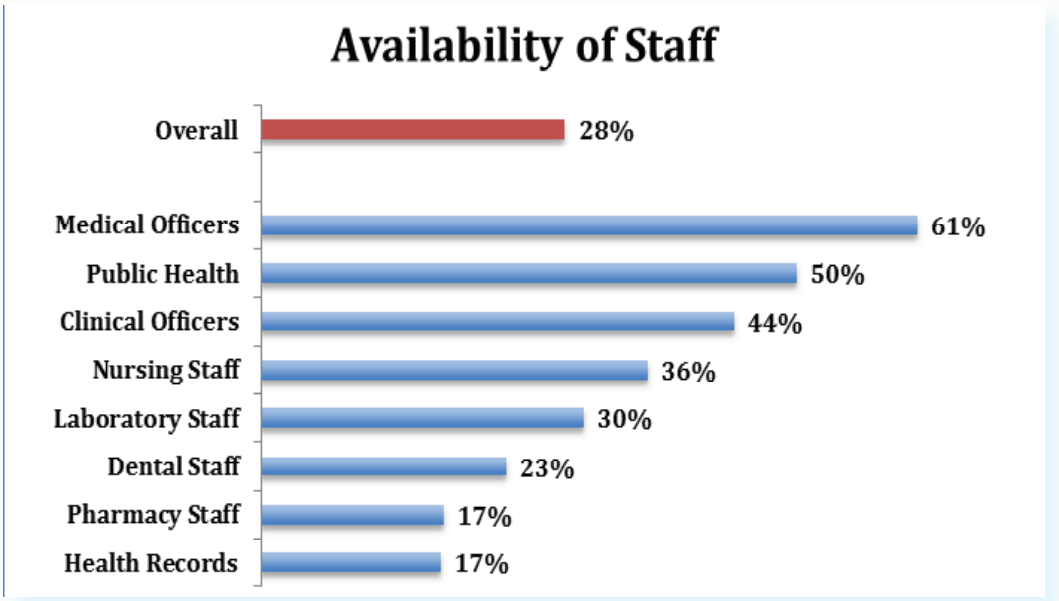
Level 5: According to the overall County population, Kitui County should have one health facility that is able to carry out Level 5 functions. Currently, there is no facility that's able to perform these functions, although there are plans to upgrade some of the existing Level 4 facilities to be able to do so.

18 Kitui County Rationalization of Health Facilities for Equitable Access to Health Services Policy Direction, April 2015

3.1.2 Staffing

Apart from availability of the health facilities, one of greatest challenges to availability of health services is the availability of the right number and skill mix of human resources for health. Shortage of staff (and inadequate mix of the staff) affects the variety of services that can be available, the duration of service (hours of operation) and even the quality of services delivered. Based on staff establishment data received from the County, Kitui is operating at 28% of the minimum required staff (Appendix 13). This critical shortage in staff affects all the cadres, both service delivery and support and management staff. For instance, the Doctor to population ratio is 1:22,005 compared to the World Health Organization's recommendation of 1:10,000; while the Nurse to population ratio is 1:1,962 against the recommended ratio of 1:1000[19].

The chart below highlights the availability of a selection of cadres in Kitui County.



In interviews with the health facility managers, it emerged that the health facilities are staffed at less than optimal levels. For instance, most dispensaries are staffed by only one nurse, compared to the recommended minimum of two nurses per dispensary[20]. 74.22% of the staff interviewed felt that the staffing levels should be improved.

The critical shortage of staff was not only raised as a concern by the staff and managers, but also by the community members. An estimated 33.7%

19 Kitui County Integrated Development Plan, 2013-2017, p.40

20 Norms and Standards of Health Service Delivery, p.9

of the clients interviewed felt that the staffing levels should be improved; 79.5% of these were at Dispensaries and Health Centres. 3 of the clients interviewed did not receive all the services they needed due to the absence of the appropriate health care provider at the facilities they visited. In addition 1 client in a dispensary was asked to wait as the relevant staff had all taken a lunch break. This challenge was noted as a problem likely to recur in the facilities where only one specialized medical professional is staffing a unit. One client attending a sub-district hospital reported that she was asked to come back another day because the queue was too long. The study did not establish if she was given a preliminary assessment before being asked to return, or at what time she arrived.

> *"Hao watu wameongezeka na madaktari ni wale wale tu. Saa zingine utaenda upate daktari ni mmoja na akiingia hapa asubui anafanya kazi mpaka jioni. Na saa zingine hiyo hospitali ni yeye tu peke yake. Kama ako kwa dawa ni mmoja, kama ako hapo pa kuandikia na kusikiliza ni yeye tu mmoja. Sasa at least wangeongezewa daktari hapa tungekuwa afadhali. Tukienda huko maternity unapata maternity ni yule anahudumia watoto ndiye yule anahudumia wamama, nao ni wengi."*
>
> Community Health Worker, Mwingi Central

Translation:

> *"The population has increased and the doctors are the same. Sometimes you'll go and find just one doctor. And when she comes in the morning, she'll work until evening. Sometimes she's the only one in the hospital. She's the one dispensing drugs, she's the one consulting. If at least they would increase the number of doctors, we would be better off. When you go to the maternity, you find it's the same doctor; she's serving the babies and she's also serving the women, and they're many."*
>
> Community Health Worker, Mwingi Central

The shortfall in human resources for health is not unique to Kitui County, and has also been recognized in the Health Sector Human Resource Strategy[21], in which the National and County governments commit to work towards a reduction in the gaps in staffing. Kitui County has also committed towards the increase in the number of staff to bring the number closer to the minimum recommended over a number of years. This effort will require a sizable investment by the County government.

3.1.3 Supplies and equipment

The views of medical personnel and clients attending the facilities were that the levels of drugs and supplies have increased significantly since the devolution of medical services. Administrative personnel observe that Kitui County has been able to plan better and dedicate more resources to purchase of essential medicines and equipment. The study found that while

21 Ministry of Health. Health Sector Human Resources Strategy, 2014-2018

there appears to have been improvements, the adequacy and consistency of supplies and drugs remained low and affected the availability and continuity of health services.

50 clients – 31 in health centres, 9 in dispensaries, 9 from the sub district hospitals and 1 from a district hospital – were unable to receive the drugs and other medical supplies necessary for their complete care. 12 clients – 2 from dispensaries and 10 from health centres – did not receive all the recommended services due to missing equipment and services, including X-ray services.

31.22% of the clients interviewed felt that the pharmacy services (availability of drugs and supplies) should be improved; 78.76% of these were at the Dispensaries and Health Centres. 56.25% of the staff interviewed felt that adequacy and consistency of drugs and supplies should be improved. 69.44% of these were from Dispensaries and Health Centres.

3.2. Accessibility

3.2.1. Physical/Geographical Access

The geographic location of health services can have a direct impact on health outcomes within counties, by affecting how quickly patients can seek care when faced with illness and injuries.[22] According to World Health Organization (WHO) standards, one should either live within 5km radius to the nearest health facility or reach the health facility within 30 minutes using whatever means is locally available.

On average, the distance to the nearest health facility in the County is 10.2 km.[23] the percentage of the population accessing health facilities within 5 kilometres ranges from 51.2% in Kitui South to 98% in Kitui West. On average, 80.6% of the Kitui County population lives within a 5 km radius to a health facility while 19.4% travels for more than 5 kilometres to access a health services from a health facility (see table below).[24]

The Ministry of Health and Sanitation in Kitui County through its Mission seeks to provide accessible, affordable quality healthcare services to all through strengthening the health care systems, scaling up health interventions, partnership and innovations and empowering communities to foster sustainable social and economic growth.[25] Physical access to

22 http://www.who.int/choice/geoaccess/en/

23 Kitui County Integrated Development Plan 2013 – 2017, p.40

24 Kitui County Rationalization of Health Facilities for Equitable Access to Health Services Policy Direction, 2015

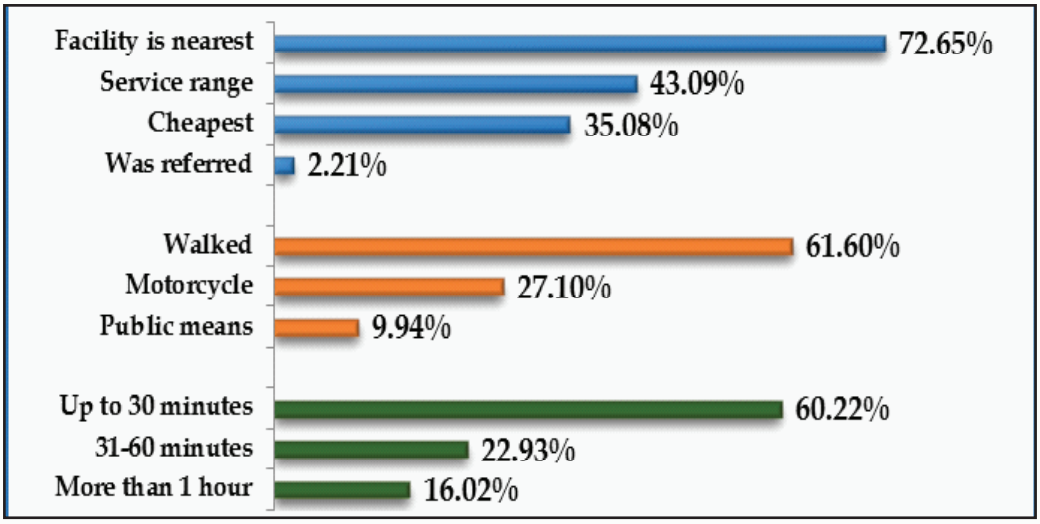
25 Kitui County Integrated Development Plan 2013 – 2017, p.209

health services and facilities in the County is hindered by poor intra-County roads; most of which are impassable during the rainy season. The County Integrated Plan acknowledges the need to upgrade access roads to all weather and upgrade major roads to bitumen standard.

Assessment of the Population Living Within a 5km radius of a Health Facility

Sub-county	Population	Area (km2)	HF:Pop ratio	% Pop <5km	% Pop > 5km
Kitui Central	131,715	636.2	1:3659	95.6	4.2 (5.1-6 km)
Kitui East	123,239	5119.1	1:5358	62.7	37.3 (6-18 km)
Kitui Rural	104,443	1560.8	1:4352	71.4	28.6 (5.1-7 km)
Kitui South	166,050	6133.7	1:5535	51.2	48.8 (6-23 km)
Kitui West	102,314	667.2	1:5385	98	2 (5.1-8 km)
Mwingi Central	141,207	4140.6	1:4153	84.8	2 (5.1-8 km)
Mwingi North	139,967	4769.6	1:4999	85.5	14.5 (6-17 km)
Mwingi West	103,774	1600.7	1:2883	95.8	4.2 (6-7 km)
% of population living within 5km radius to a health facility					**80.6%**
% of population living outside 5km radius to a health facility					**19.4%**

Geographic access may be measured by modes of transportation, distance, travel time, and any other physical barriers that could keep the client from receiving care. The study established that 72.7% of the clients consider geographical proximity of the facility as the main factor in determining the facility they will visit (see chart below). 61.6% of the clients walked to the health facility, and 60.22% of them took 30 minutes or less to get to the facility.



In interviews with the clients and community members, it emerged that the road networks and access to means of transport is a major challenge. This forces many of the clients to align their visits to health facilities with market days, when means of transport are more readily available. Interviews with Facility in-charges corroborated this, as they indicated that the numbers of clients are more during market days and after a weekend (especially for health centres and dispensaries which do not open over weekends and nights).

Public transport was the means of travel for only 10% of the clients interviewed. These clients travelled mainly to Level 4 (County) and Level 3 (Sub-County) facilities where specialized equipment and services and drugs are more available. The Kitui study noted that Mwingi North and Mwingi Central sub-counties had specific challenges of availability of healthcare facilities within reasonable geographical proximity to the communities. Clients seeking medical services often have to travel distances of one hour or more and the transport system is unreliable – for example in Mwingi North, matatus ply certain routes once or twice a day and community members wishing to travel must do so in synchrony with the matatu travel times. This makes access to the facilities tedious, time consuming and uncertain.

Significantly, it was noted that 98 clients (27.1%) used motorcycle transport (boda boda). This is important given the concern that motorcycle accidents form a significant proportion of the accident and emergency cases received in health facilities in the County. Only 5% (18 people) used private means including bicycles, motorcycles and cars.

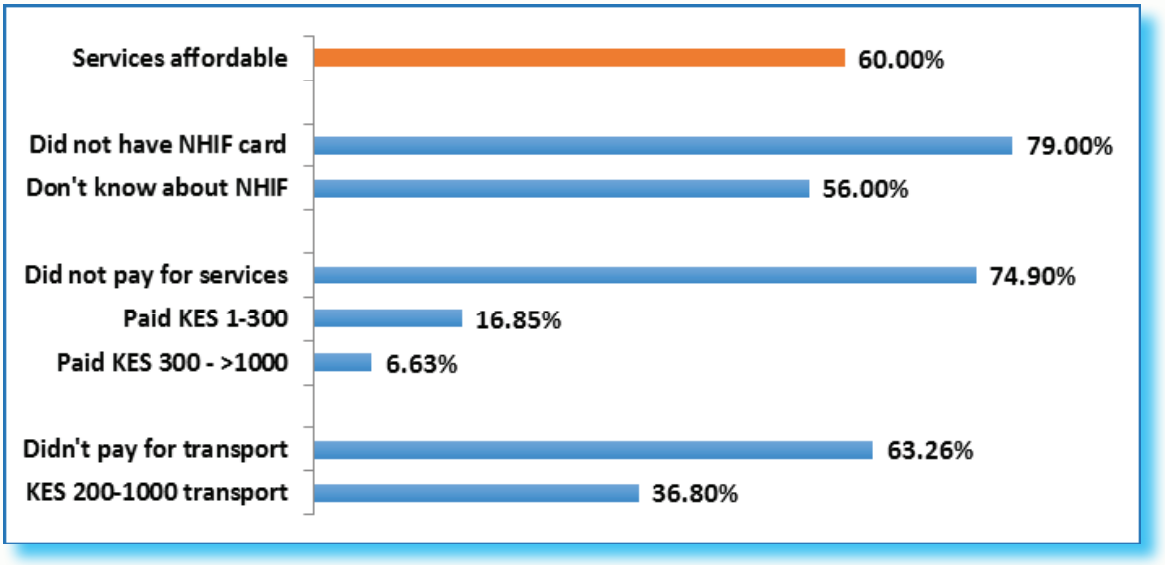
In an effort to improve access to health services for the populations living in hard-to-reach areas, the Ministry of Health and Sanitation procured 3 mobile clinics; one of which was a donation through the First Lady's Beyond Zero Campaign. In addition, they also got a mobile clinic that focuses on cervical cancer screening.

> *"At the starting point we mainly focused on the most remote and hard-to-reach areas… Here we have facilities far apart and the patients walk for long distances… So our main target is the hard-to-reach area. We have been to Kitui Central, Kitui West, Kitui South and Kitui East. …when we visited one of the most remote areas in the county we are able to reach women who've never gone to hospital. And in fact out of that screening, we got two mothers who were reactive in terms of human papilloma virus. And these are mothers who never go to the clinic. We're also able to reach even children who had defaulted in terms of immunization."*
>
> Monica Mutisya, County Nursing Officer

3.2.2. Economic access

Economic access refers to the affordability of products and services for clients, influenced by both the direct and indirect costs incurred in the pursuit of health services. The Kitui County Integrated Development Plan 2013-2017[26] recognizes that high levels of poverty and low levels of disposable income impede access to health care.

Majority of the clients interviewed (74.9%) did not pay for the services they received. Of these most were receiving services in health centres and dispensaries. More than 85% of those receiving services at Level 2 and Level 3 facilities did not pay. Interviews across the County established that consultation fees range between Kshs 1 to Kshs 30 and thus the bulk of costs incurred are in specialized followed up services and purchase of medicines. 22.1% (80) of the respondents paid for the services received. Majority of these incurred costs not exceeding KES 300, nearly all of which (97.5%) was paid in cash. Most costs were incurred at District and Sub District Hospitals. 3 of the respondents – 2 from sub-district hospitals and 1 from a health centre – were waived from paying for their health services.



36.8% of the respondents incurred transport costs ranging from KES 200 to KES 1000, the majority of whom were in Mwingi North and Mwingi West. Transport costs are one of the indirect costs of accessing health care, and can significantly reduce the willingness to access health services on time.

Out of pocket expenses introduced due to missing services or supplies are another form of indirect costs. In this study, it was found that 50 clients

26 p.40

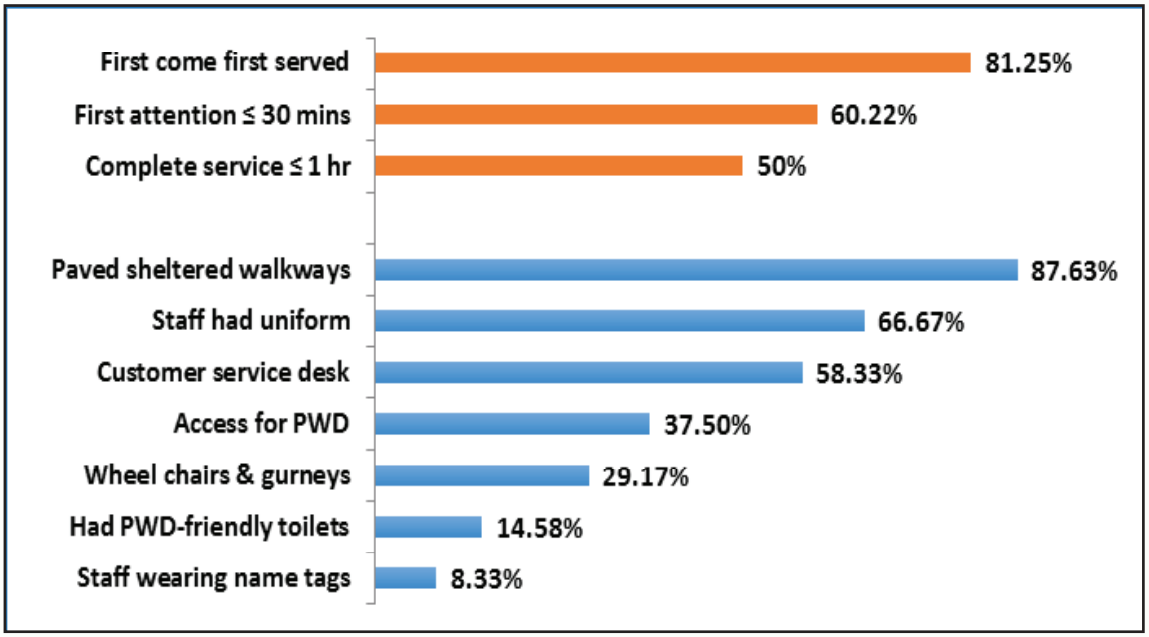
(13.81%) did not receive the drugs prescribed, and were therefore asked to buy them from a Chemist, which could be more expensive than the cost at the government health facility.

When queried on their views on affordability, only 60% of the clients perceived the costs to be affordable while 40% did not think they were affordable. Notably, up to 91% of the clients in Kitui South stated that the services were not affordable. These were clients attending Ikanga Sub District Hospital. 50% of those in Mutitu Sub District Hospital in Kitui East were also of the view that the services are not affordable.

Up to 79% (286 respondents) indicated that they did not have a National Health Insurance Fund (NHIF) card. Of those who did not have cards 56% did not know about the cards and 12% did not think the card was important. A further 16% said they could not afford the card. There is a significant gap in knowledge about the NHIF card and healthcare payment systems. It would be beneficial to carry out a County-wide campaign on the NHIF health care payment system.

3.2.3. Organizational access

The efficiency in the structure and management of the health facilities is an important aspect of rights based approach as it has implications for access to the facility and the services within. Organizational access includes factors such as working hours, appointment systems, waiting time, eligibility criteria, arrangement of rooms, physical layout, and modes of service delivery (e.g. facility-based and outreach services).



Client reception

The study observed that 81% of the facilities had an established system for receiving and attending to clients, such as first come, first served, with exceptions made for emergencies. Analysis of the facilities during an observation exercise revealed that 4 of 17 dispensaries in Mwingi West, Kitui Rural and Kitui West did not have a clearly discernible system or chronology for receiving and attending to clients. This number could indicate that up to 24% of the county dispensaries may lack a clear system for patient reception and service.

Having a Customer Care desk can make it easy for clients to find their way around the health facility. Just over half of the facilities assessed (58%) had customer service or general enquiries desks or points that were visible. All the County hospitals had enquiries desks while 75% of the sub-district hospitals had these desks. Notably, 83% of the facilities assessed in Mwingi West did not have enquiries desks. By contrast, 83% of the facilities in Kitui Rural had enquiries desks.

Waiting times

From the study it was noted that 60% of the clients were attended to within 30 minutes; 17.7% waited between 31 minutes and 1 hour; while 18.78% waited more than an hour. Some important statistics drawn from the study among the 362 clients on waiting times are:

Pre-service waiting times

- The 60% who receive their first medical attention within 30 minutes were divided as follows – 53 clients attending dispensaries, 50 at health centres, 103 clients at sub-county hospitals, 12 at the county hospitals received first medical attention within 30 minutes.
- For 17.7% (64 clients) for whom first medical assistance took up to an hour wait, 16 clients were in dispensaries, 27 in health centres, 15 in sub-county hospitals and 6 at the county hospitals.
- For the clients who took more than an hour before receiving their first medical attention (18.78% or 68 clients), 17 were at dispensaries, 18 at health centres, 22 at sub-county hospitals and 11 at county hospitals.

Total service time

- The clients who took less than an hour overall were 59 at the dispensaries, 89 in health centres, 27 in sub-county hospitals and 6 at the county hospitals (total 181 or 50%)
- Total service times ranged between 1-2 hours for 23 clients at dispensaries, 53 clients at health centres, 22 clients at the sub-district hospitals and 9 clients at district hospitals – in total, 29.6%.

- Clients who took more than 2 hours included 6 at the dispensaries, 15 at the health centres, 28 at the sub-district hospitals and 14 at the district hospitals (total 63 or 17.4%)

The study noted that clients did not always consider wait times from the moment they arrive at the clinics but may start to count their wait time from the moment of registration and payment, or from the moment of the initial triage. This indicates the need for reviewing further the actual wait times at every stage of health service delivery. An estimated 27.9% of the respondents felt that the time taken to offer services is too long and should be reduced. This was also confirmed during the focus group discussions with the community members in which they frequently complained about the lengthy wait times in the facilities.

Completeness of service/Continuity of care

The study noted that 82% of those who sought medical attention received the services recommended by the healthcare provider on the day that they visited the facility. Reasons given for not receiving all the services recommended included missing drugs and supplies (50 clients) and missing equipment and services like x-ray (12 clients). Majority of clients (62.7%) that did not receive all recommended services were visiting health centres. In an attempt to improve continuity of care, the County Ministry of Health and Sanitation procured 17 ambulances in the 2014/2015 financial year. 11 of these ambulances were procured in June 2015, and were distributed to Malalani and Zombe (Kitui East), Mui and Ukasi (Mwingi Central), Kisasi (Kitui Rural), Migwani (Mwingi West) Kabati (Kitui West), Ikutha, Mutha and Ilengi (Kitui South), and Tharaka (Mwingi North). The ambulance system will need to be further strengthened by providing accurate information to the community on its availability, any charges related to its use, and the importance of responsible use of the resource. The ambulances also need to be fully equipped to adequately manage referrals from one health facility to another.

Accommodations for Persons with Disability

While movement within the health facilities is fairly easy for majority of the population, special measures are often necessary to ensure ease of access for those with conditions that would otherwise impede movement within the facilities. Interviews with health service providers indicated that that persons with disability and elderly persons have the greatest difficulties in gaining access to health facilities.

12 out of the 362 clients interviewed had disabilities; 6 had physical disabilities, 3 had visual disabilities, and 1 each had a hearing, intellectual, and a combination of physical and intellectual disability. The County may need to explore whether the client data cards can be modified to capture information about any disabilities that the clients may have in order to be able to appropriately respond to the needs of persons with disability.

A total of 48 facilities were assessed through observation. All the three county hospitals were found to all have wheel chairs and wheeled beds or gurneys allowing access for people who are unable to walk. It was found that only two of six dispensaries (indicating a rate of 15% of similar facilities) had wheel chairs, wheeled beds or trolleys. The study further found that half of those that had wheel chair ramps, had incorporated them at a standard that allows for ease of movement up and down the ramps.

On the other hand, up to 63% do not have ramps to facilitate wheel chair access. 81% of the dispensaries assessed had no wheelchair access ramps while 100% of the county hospitals had wheelchair ramp access ways. Similarly, toilets that facilitate easy use by persons with disabilities were not available in 83% of the health facilities sampled.

Experiences of persons within the health services were diverse. Young people living with visual impairment at the ACK Youth Centre reported that they get a waiver (a letter of exemption) to access services from Kitui District hospital so that they do not pay for services, such as laboratory tests. However, when they visit the facilities, they queue with the other clients and the waiting time can be quite long. Other persons in the county with visual challenges reported that they do not receive assistance to access services within the health facilities. They may rely on someone else to help them navigate the process or ask fellow clients to help them to get around.

> *"Like me when I go there, because I am blind, I should be received and they should say please lets help this one not to queue..."*
>
> Elderly Woman with visual impairment, Mwingi Central

Other Clients with challenges to access

66.4% of the staff interviewed believed that there are some clients who may have challenges accessing health services. Among them are persons with disability, elderly persons, persons living with HIV, expectant women, very poor persons, orphans and vulnerable children, young mothers, and youth or adolescents.

On the other hand, 54.7% of the staff admitted that there are some groups of clients that they find particularly challenging to serve for various reasons. 31.4% identified violent clients, 27.1% drug users or intoxicated clients, 25.7% identified persons with disabilities, and 11.43% identified politicians as being particularly difficult for them to serve.

Inadequate resources were mostly associated with the difficulty of serving persons with disabilities (42.9%) and violent persons (35.7%). Inadequate knowledge and skills was mostly associated to serving persons with disabilities (56.3%) and drug users/intoxicated persons (25%). The persons with disabilities identified by most as being challenging to serve were those with mental disabilities and deaf and dumb persons. Members of the Kavonokya religious group were identified as persons who may have challenges accessing healthcare, as well as persons who may be difficult for the health workers to serve.

The rights based approach and the Constitution of Kenya emphasizes the need for inclusiveness and non-discrimination. This requires specific measures to be taken to ensure disadvantaged populations; minorities and marginalized groups have equitable access to the facilities and health

services. Such measures include taking steps to understand the factors that impede access for such populations and addressing these impediments to increase access.

3.2.4. Information access

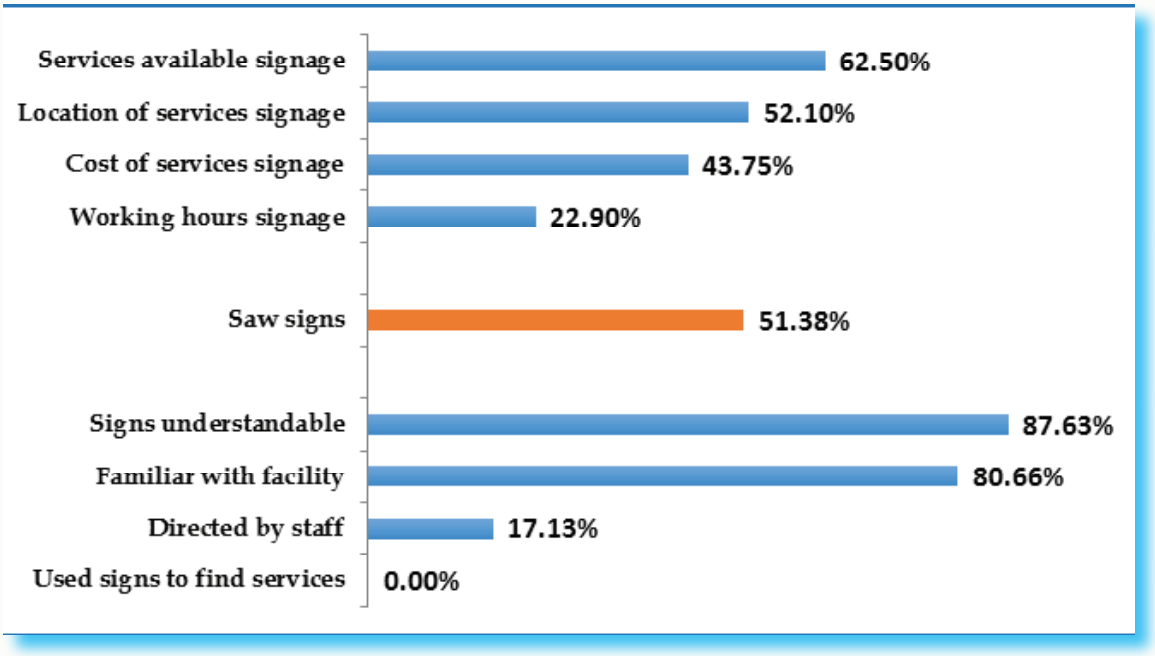
Signage within the health facility

An assessment of the availability of signs providing information to clients was done in 48 health facilities. The study established that 62.5% of the facilities have signs showing which services are available at the facilities. However, only 52.1% were found to have clear signs indicating where within the facilities the services can be found.

Only 23% had signs showing the opening times, closing times and what time the services are available. Only 43.8% clearly indicated the costs of the

services. Notably, all the sample facilities visited in Kitui West[27] had signs put up indicating the costs of services. In addition, all eight (8) sub-County hospitals had charters that included costs of services.

The signs and charters were found to be prominently placed in visible locations in 62.5% of the facilities assessed. These locations included the reception, waiting area, entrances, etc. However, it was noted that in Mwingi West, none of the facilities assessed had signs in visible locations. In a number of cases, it was found that the jargon used on the signs and notices is much more suited to communicating with other health professionals, and not necessarily members of the community. For instance, the use of terminology like VIA/VILI, PMTCT, among others limits access to information about the services being offered. The County could develop simple symbols that are meaningful to the clients and that easily communicate the nature of services being offered.



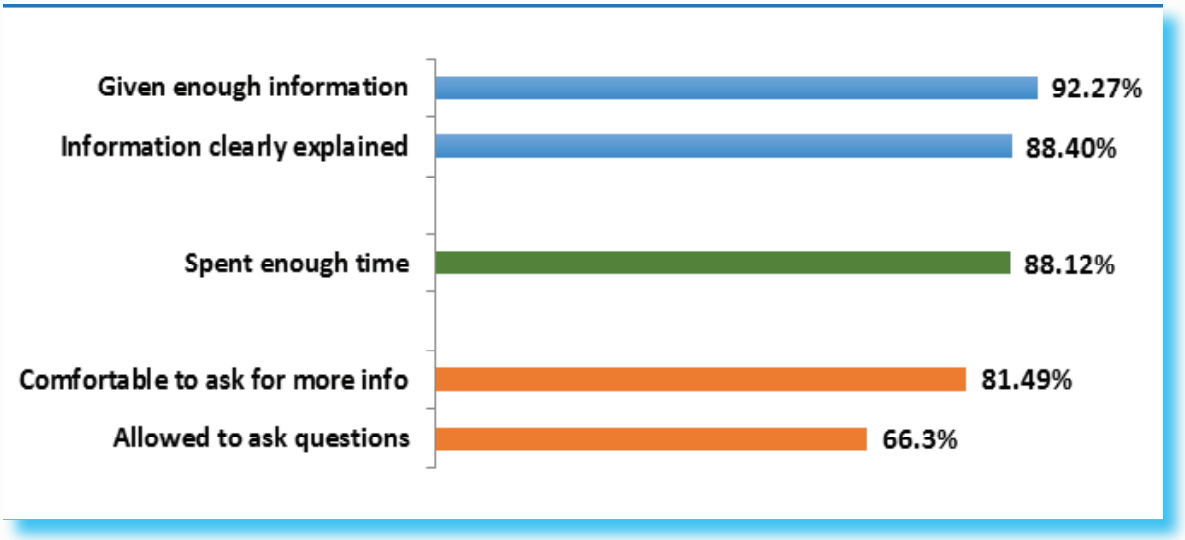
51.4% of the clients saw the various signs at the health facilities they visited. Of these, 87.6% of them indicated that the signs and notices were understandable to them. Nearly 50% of those who saw the signs were aged between 18 and 30 years, 36.8% were aged between 31 and 50 years, 8.6% were between 51-65 years, while 4.9% were over 65 years. Fifteen (15) clients saw the signs but did understand them while 8 could not read at all. When asked how they found their way around the health facility, 80.7%

27 Kakeani Dispensary, Kiseveni Dispensary, Kwamutonga Dispensary, Matinyani Dispensary, Tulia Dispensary and Kauwi Sub-County Hospital

of the clients indicated that they were familiar with the facility and 17.1% asked for directions from staff. It was significant that none of the clients used the signs to find the services they needed in the facilities they visited. While nearly half the client population is in the under-30 age category, literacy and use of signs varies and reliance on written signs may exclude a significant proportion of clients. This underscores the importance of having a Customer Care desk in facilities from which the clients can seek guidance.

IT WAS SIGNIFICANT THAT NONE OF THE CLIENTS USED THE SIGNS TO FIND THE SERVICES THEY NEEDED IN THE FACILITIES THEY VISITED

Client education and information



The vast majority (over 90%) of those interviewed felt they received sufficient information about their condition and that staff explained information clearly. In addition, 88% were satisfied with the time spent with the healthcare providers in discussing their needs. Generally, 81.5% felt confident about asking for further information from the health care provider where they did not understand any aspects of their care. However, it emerged that while clients felt confident to ask, only 66% of the clients who had follow-up questions had the opportunity to ask and 22% felt they did not have any opportunity to ask.

The degree to which clients feel comfortable to express themselves is an indication of their level of trust in the medical personnel and confidence in their queries being listened to and answered. It speaks to the quality of consultation, as it is preferable for the service provider to ensure the client leaves satisfied. This includes prompting them for any questions they may have from the consultation. Interpersonal communication is considered effective when it leads to the patient disclosing adequate information and leads to an accurate diagnosis. As a result the provider is able to select an appropriate treatment that is acceptable to the client and the client understands his/her condition and the prescribed treatment regimen. The communication should also enable the client and the service provider to establish positive rapport.

Interviews with facility-in-charge personnel indicated that communication between the facility and the community is done mainly through use of posters or written notices in and outside the health facility, written in English, Kiswahili, and vernacular. While notable, the use of posters is not likely to be an effective medium as this study found that most clients don't seem to pay attention to signs and notices. In addition, persons who cannot read and write will not be able to read the posters, regardless of the language used to write them.

The facilities also use other communication channels such as health education talks within the health facility, Chief's barazas, religious (Church) gatherings, schools, Public Health Officers, and Community Health Workers/Volunteers where available. It was significant that mass media was not mentioned by any of the staff as a method through which the health delivery system communicates with the community. Discussions with the youth indicated that the use of vernacular oral media

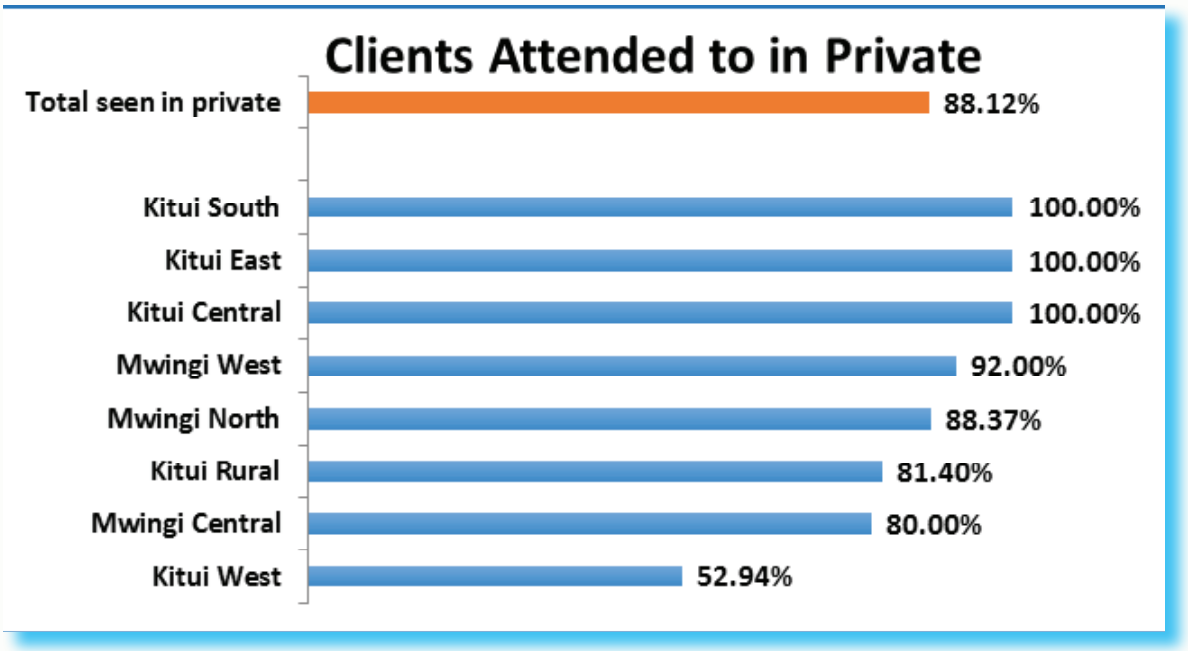
would be effective in communicating across the county, especially with the elderly and persons who cannot read and write. In addition, with the high penetration of cell phones, radio access is improved. They also recommended that health facilities should have a Customer Care Desk.

3.3. Acceptability

Acceptability relates to the extent to which the delivery of health services is respectful of medical ethics, socio-cultural norms, individuality and human dignity. Acceptable health services respect privacy and confidentiality, and promote choice, informed decision making, and the freedom of expression. Acceptability of health services can affect their utilization, in spite of being available and accessible.

3.3.1 Privacy and Confidentiality

Privacy is important in guaranteeing respectful service for individual clients. It allows the client to open up and share all their concerns with the health worker so that the right decisions on their care can be made. In Kitui County, 88% of clients interviewed were seen in private. Facility observation established that 93.75% of the facilities conducted consulting sessions, physical examinations, and procedures in a private space to ensure that they could not be overheard or observed. It was also observed that staff did not walk into consultation rooms while clients were being attended to in 77% of the facilities.



The challenge of lack of privacy was prevalent in facilities in Kitui West in which 16 of 34 clients, or slightly less than 50% stated they were not seen in private. Specifically, majority of the clients interviewed in Kauwi Sub-district Hospital and Kiseveni Dispensary in Kitui West were not seen in private. A similar pattern was observed in Mwingi Level 4 Hospital (Mwingi Central) where 80% of those interviewed were not attended to in private.

The arrangement and placement of services within a facility can interfere with their uptake (utilization) due to privacy concerns. In this study, two services in which concerns of privacy and confidentiality may reduce their utilization were assessed.

Observers were asked to determine if they could easily identify a separate room or building for HIV Care and Treatment. In 60.42% of the facilities observed, it was easy to identify the room or building dedicated for HIV care and treatment. While this separation of services ensures that persons living with HIV access quality health services, it can also be a barrier to access due to stigma.

When the community members associate going to a particular building or room with receiving HIV care and treatment, it could potentially introduce barriers to access to those who may still be dealing with issues of stigma. In addition, even for those clients who are comfortable going to this room or building, their privacy and confidentiality is contravened to some extent.

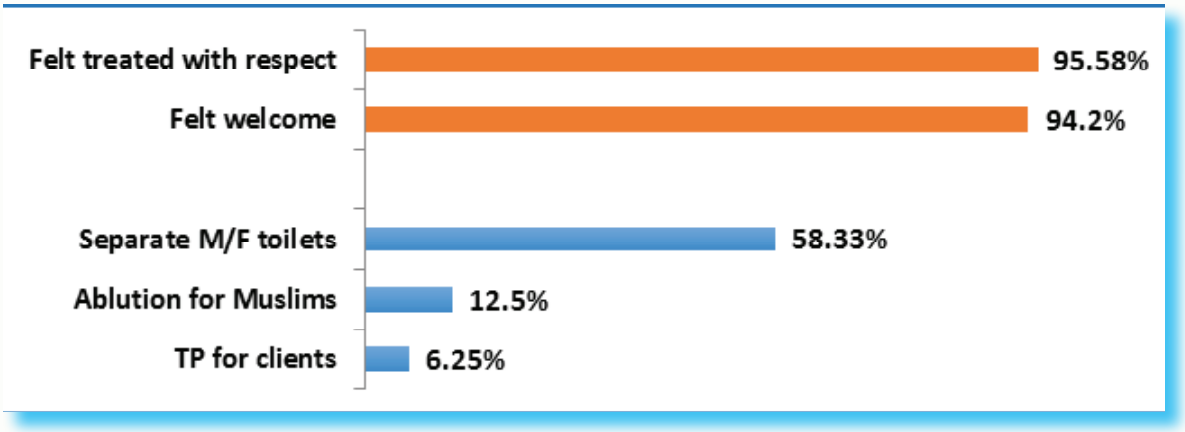
Related to HIV prevention, an assessment was conducted of the placement of condom dispensers

within the health facility. While many of the facilities have prominently placed condom dispensers (e.g. at the reception area), the assessment conducted in this study sought to establish if the facilities have the dispensers in the toilets, where it is expected that clients would be more comfortable accessing the condoms in private. Of the 48 facilities assessed, only 2[28] had stocked condom dispensers in the male toilets while none had stocked condom dispensers in the female toilets.

This aspect of organizational access could be a major barrier to utilization of these and other services. Health facilities should assess how the organization of their services either enhances or reduces acceptance and uptake of the services.

3.3.2 Dignity, Comfort and Respect

The concept of dignity communicates a person's innate right to be valued, respected, and treated 'like a human being'. In the context of health service delivery, it relates to the things that health workers can do to demonstrate that they value and respect their clients and view them as worthy human beings. This can include the provision of amenities like sheltered waiting bays with adequate seating and ventilation, and clean toilets with ablution and cleansing facilities, as well as how staff relate with clients.



95.6% of the clients interviewed indicated that they felt treated with respect, while 94.2% felt welcome at the facility. This is important as it improves the acceptability of health services by the community members. Where staff are found to be disrespectful or inhumane in their treatment of clients, the community members can minimize their interaction of health services to only extreme cases of emergency where they have little or no choice.

28 Kyuso District Hospital and Ngomeni Health Centre (both in Mwingi North)

Toilets were available in all the facilities assessed and there were separate facilities for male and female users in 58% of the facilities. In addition, the toilets were unlocked in 83% of the facilities. This is important because locked toilets in health facilities often mean clients have to keep asking for the keys to use the toilet and may result in people using alternative areas to relieve themselves.

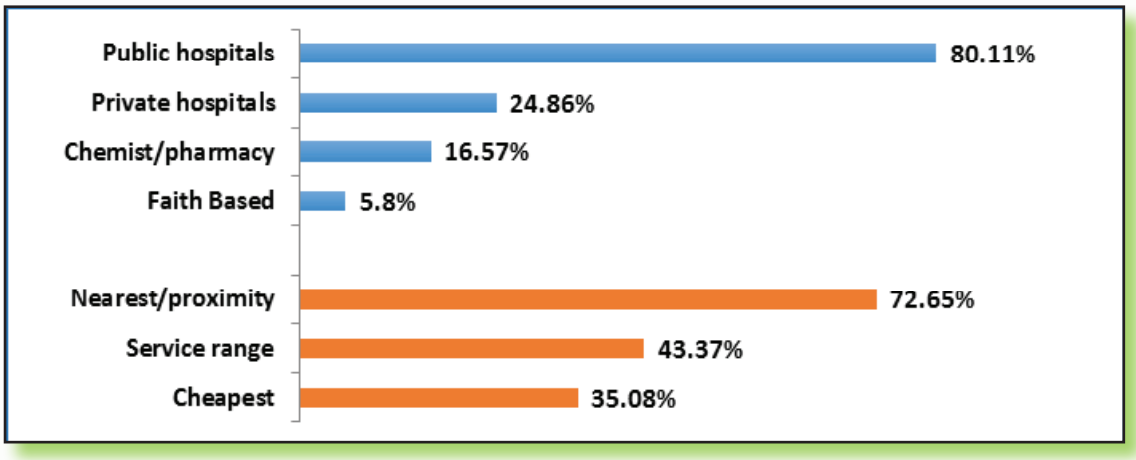
During the assessment of the health facilities, it was found that only 6.25% and 12.5% had provided toilet paper for clients and ablution facilities, respectively. Progressive realization requires that facilities must have a toilet, even if one initially used by both sexes. The target however, should be to have separate toilets for male and female users as well as ensuring the toilet facilities are accessible to persons with disabilities, elderly persons, and persons who require ablutions (e.g. Muslims). This demonstrates recognition of and respect for cultural and individual needs of the clients.

While majority of the facilities had clean, well-ventilated, and sheltered client waiting areas, the seating space was not always adequate for the volume of waiting clients (77% had adequate areas). The adequacy of the seating space depended on the volume of clients, which varied depending on factors like the day of the week. Some facilities experienced an influx of clients on Mondays (after the weekend) and during market days and a decline in numbers on other days of the week. Factors such as distances, costs and time played a significant role in determining when community members visited health facilities.

3.3.3 Choice

When asked where they would seek health services, government hospitals were the most preferred healthcare facility choice for community members by a large margin (see chart below).

When deciding which health facility to visit, the top three criteria used by the clients include the proximity of the facility (72.7%), the range of services available at the facility (43.4%), and the cost of the services (35.1%).



29.6% (107) of the clients interviewed said that there are services that they would prefer to seek elsewhere, and not at the facility they had visited on that day. Most of the services identified largely had to do with services that were missing at the health facility they had visited. Of the 107 clients, 25.2% would visit another facility due to missing laboratory services, 22.4% due to missing x-ray services, 13.1% due to surgical services, 10.3% due to delivery services, 6.5% due to specialized care, and 4.7% due to inadequate supply of drugs, among other reasons.

Culture and Health

Members of staff, clients, and community members repeatedly mentioned the Kavonokya religious group, whose members do not use conventional healthcare and rely on prayer for healing. Based on the discussions about this group, it emerged that there have been instances where members of the sect may have been forced to consume conventional healthcare, which goes against their religious beliefs and practices. In fact, there were reports of using the police to enforce compliance and sometimes having some of the members arrested for refusing to comply.

The rights based approach would require respect for personal and cultural beliefs, values and practices. Capacity strengthening among the County Ministry of Health and Sanitation staff is necessary to enhance their ability to respect, protect, promote and fulfil the right to health for groups that are religious or culturally diverse. Respect for one's religious and cultural beliefs in choosing their health care and they generally should not be forced to participate in healthcare that contravenes their beliefs. This can only be superseded in cases where public health and safety are at risk. In addition, for cases involving minors or during airborne or waterborne epidemics, the Ministry can intervene to protect the health of the general public.

3.4. Quality

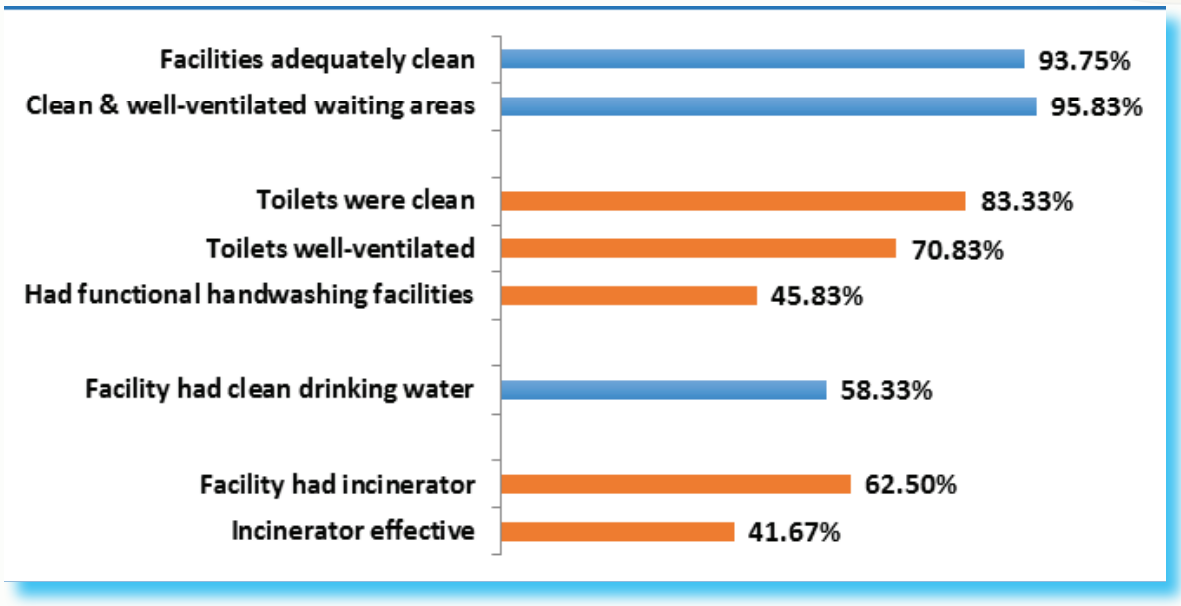
The element of quality in health services delivery requires medical facilities to ensure they offer medically appropriate, good quality services, equipment and supplies, have appropriately skilled medical personnel, and also provide a safe, clean and healthy environment, including access to safe, potable water and adequate sanitation.

3.4.1 Cleanliness, Water, and Safety

To protect clients, health workers, and the community, 'standard precautions', which are basic infection control precautions, must be applied at all times. Environmental cleaning and appropriate handling of waste are some of the essential work practices that fall within the category of 'standard precautions' in infection prevention practices. Assessment of infection prevention at the facilities in this study was limited to a basic assessment of cleanliness and presence of an incinerator or burner due to the technical ability of the data collectors.

Routine cleaning of the health facility helps to ensure a clean and dust-free environment and minimizes the micro-organisms that have been found to be present in "visible dirt". 94% of the facilities were clean and free of unpleasant smells, and 96% had clean and well-ventilated client waiting areas. Good ventilation in the facilities helps to minimize the transmission of airborne infections.

More than 70% of the staff took pride in the standards of cleanliness and sanitation maintained in the facilities. During the assessment, it was clear that access to water in the facilities was a challenge, suggesting that while the facilities may be kept clean, clients and possibly staff have inadequate access to clean water in the health facilities, whether for drinking or for ablutions. It was observed that 58% of the facilities had drinking water available for clients. It is therefore noteworthy that in spite of the challenges in getting water, the facility staffs still prioritizes the cleaning of the facilities.



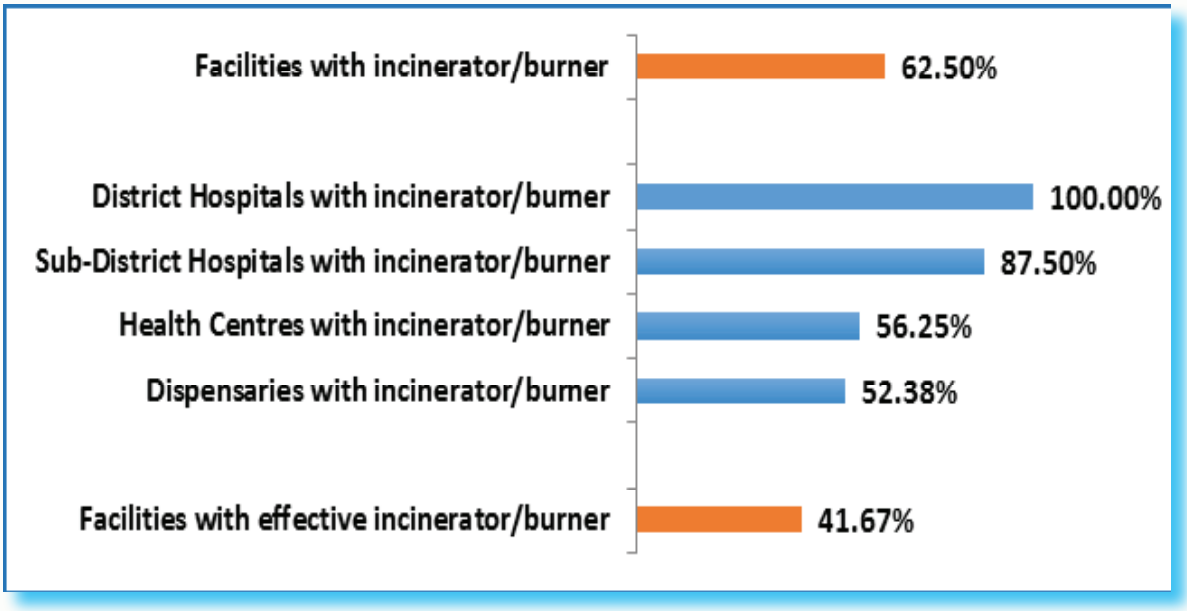
83% of the facilities had clean toilets, 71% of the toilets were well-ventilated, but only 46% of the facilities had functional hand-washing facilities for clients after using the toilets. One of the most common modes of transmission of micro-organisms is through hands, and handwashing has been found to be an effective approach in reducing the transmission of infections. This is even more critical within the health facility, where the chances of transmission of disease-causing microorganisms is even higher. The inadequacy of water for hand washing is therefore a challenge that needs to be addressed in order to improve the standards of infection control within the health facilities.

An important aspect of the right to health is having good, safe, potable water. The varying findings related to water indicate the need for a county-wide review on access to water for staff and clients, both for washing, drinking and ablutions.

Hospital waste is a potential reservoir of disease-causing micro-organisms and should be handled appropriately to ensure the safety of clients, staff and the community. While the management of hospital waste includes various precautions right from the generation, segregation and separation,

collection, transportation, storage, treatment, and final disposal, the assessment in this study only focused on the presence of an incinerator or burner and its effectiveness in burning the waste generated within the health facility.

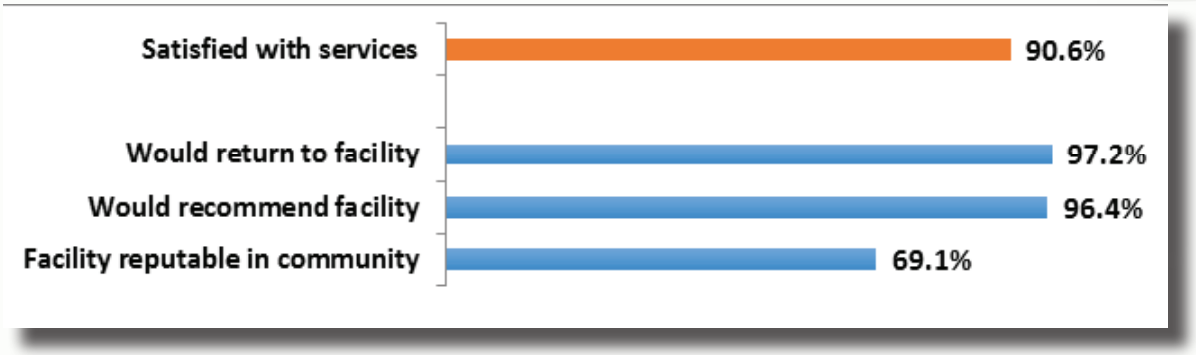
Based on the observations in Kitui, 62.5% of the facilities had either an incinerator or burners with which to burn waste generated within the facilities. All the district hospitals, 87.5% of the sub-district hospitals, and slightly over 50% in dispensaries and health centres had an incinerator or burner. The incinerators or burners were found to be effective in only 41.7% of the facilities. This highlights a critical challenge in assuring safety for the staff, clients and community as inappropriate disposal of the medical waste can contribute towards the transmission of diseases, especially through needles and other sharps.



3.4.2 Perceptions on Quality

Client Perceptions

The data indicates that up to 328 of 362 clients interviewed (90.6%) were satisfied with the services received. In addition, 97% confirmed that they would return to the facility in future if they need medical attention and 96% would recommend the facilities they visited to others in need of healthcare.



When asked what they liked about the facilities they had visited, 59.4% mentioned the affordable cost of services, 48.1% the proximity of the facility, and 39.8% the way clients are handled. On the other hand, 32.3% were unhappy about the inadequate staffing, 30.4% with the inadequacy of drugs and supplies, and 27.9% with the long waiting time. The fact that proximity and affordability are significant influences in the client's choice of a facility may imply that they may not be too picky or discriminating of the quality of service they receive. It also implies that a number of clients may not pay too much attention to the quality of services where they feel they do not have alternatives. However, these factors are top of mind for the clients and give an indication of the areas that facilities should continue to uphold as well as the areas for improvement. These factors contribute to the question of acceptability as they indicate clients' expectation levels and what amounts to good services in their perspective.

Suggestions for Improvement by Clients

	Dispensary	HC	SDH	DH
Lab services	48.04%	38.00%	23.46%	
Staffing levels	41.18%	36.67%	20.99%	27.59%
Pharmacy services	30.39%	38.67%	22.22%	20.69%
Time taken to offer services	14.71%	23.33%	34.57%	79.31%
Delivery services	23.53%	18.00%	9.88%	
Handling of clients/Nursing support	25.49%	16.00%	11.11%	27.59%
X-ray services	12.75%	17.33%	20.99%	
Cost of service	1.96%	1.33%	45.68%	37.93%
Provide 24-hour services	16.67%	7.33%	1.23%	

KEY: HC – Health Centre SDH – Sub district hospital DH – District hospital

Users of a health service can provide important information that can shed light on areas for improvement. In the Kitui study, the key suggestions for improvement were related to the laboratory services, staffing levels, pharmacy services, and time taken to offer services. Addressing these will be a first step towards mitigating the impediments towards the realization of a rights based approach to healthcare in Kitui. An assessment of the suggestions for improvement from the clients revealed the different needs for the different facility levels.

Majority of the clients visiting dispensaries felt that the laboratory services, staffing levels and pharmacy services should be improved. Dispensaries currently do not have laboratories. The fact that the request for a laboratory at this level was the topmost is an indication of the urgency of the need. The Ministry needs to explore how to bring laboratory services closer to the community, and also needs to improve the adequacy and consistency in the supply of drugs. Many of the dispensaries are staffed by only one service delivery staff, which means that the facility is closed if the staff goes on leave or for any other reason.

The requests for improvement by clients that visited the Health Centres followed a similar pattern, where majority of the clients felt that pharmacy and laboratory services and staffing levels need to be improved. While a number of the health centres have basic pharmacies and laboratories, the key challenge may be in the adequacy and consistency of drugs, supplies and reagents, as well as a challenge in having the right staff manning these sections.

The cost of services and the time taken to offer services came up as a concern among clients at both the Sub-County and County hospitals. In addition, laboratory services were raised by clients at the sub-district hospitals and staffing levels at the district hospitals.

As facilities continue to collect feedback from their clients on their strengths and opportunities for improvement, they should probe this feedback further in order to get a better understanding of the meaning of the issues raised. For instance, clients constantly requested for increase in personnel which could be interpreted as a need for an increase in efficiency and speed in going through the healthcare processes. This deeper probing may reveal innovative solutions that can be adopted to address the challenges raised.

Client feedback initiatives should explore factors that move a facility from being perceived as an average facility to an excellent facility, while those that are renowned as good should establish what factors give them this reputation and work at maintaining these standards.

Staff Perceptions

The conditions of work for staff are critical to their motivation levels and the quality of service they are able to provide, and by extension to the quality of service the clients enjoy. 65.63% of the staff interviewed rated the facilities at which they work as offering good services while 31.25% felt the quality is fair or average. When asked which factors they feel affect their ability to deliver quality services, they identified staffing levels (78%), inadequacy of drugs and supplies (45%), and inadequacy of diagnostic facilities (34%) as being the key impediments. Other factors identified included the working environment (e.g. working space, electricity, water supply, and refrigeration for immunization and vaccination medicines), training opportunities, insecurity and their managers or supervisors. The County may need to probe further to understand the meaning of these factors and determine the best approaches to improve the working conditions for the staff.

The top three suggestions for improvement were staffing levels (74.2%), drugs and supplies (56.25%), and laboratory/diagnostic services (31.25%). The top areas for improvement among the dispensary and health centre staff were staffing levels, drugs and supplies, and laboratory and diagnostic services, while the top concerns for sub-district and district hospital staff were staffing levels, drugs and supplies and cost of service. The issue of the critical shortage of staff appears to be a major barrier to the achievement of quality services that fulfil the rights of clients. Low staffing levels result in working long hours and experiencing burnout, which has been shown to also contribute to an increase in errors.

These suggestions for improvement are similar to what the clients requested, which seems to imply that they are valid concerns that could be a barrier to the realization of the right to health and the rights based approach to health service delivery in Kitui County. The Ministry of Health therefore needs to invest in these areas if progress is to be made in protecting, promoting, and fulfilling the right to health in the County. While addressing these challenges, the County should pay attention to the Ministry of Health Norms and Standards for Health Service Delivery which advises that health facilities should be equipped and staffed based on the level of functions the facility performs rather than strictly by the operational level assigned to it. Restricting services, staffing and equipment to defined health facility levels is likely to intensify shortages of essential services to populations.

3.4.3 Participation, Feedback and Accountability

Involvement of clients and communities in the health system increases the likelihood that their needs and expectations are more effectively integrated in the design and delivery of health services. Article 10 of the Constitution of Kenya provides for participation of the people as one of the values and principles of governance. This therefore requires that the health delivery system creates opportunities and puts in place suitable systems and processes to ensure that clients and the community are actively involved in and participate in the design, delivery and improvement of health services.

In total, 79.8% of clients were confident they could share their views and feedback with the healthcare personnel, while 14.4% did not think it was possible m to do so. Kitui South stood out as more than 34% of the respondents were uncertain about giving feedback while 22% were certain they could not do so. The factors that create low client confidence in feedback and the right to be heard on healthcare standards, quality and facilities should be examined specifically and measures taken to encourage clients to give feedback on services. This will facilitate targeted improvement of services.

56.4% of the respondents indicated that they would feel more at ease sharing their feedback with a member of staff, 19.6% would use the suggestions boxes, and 22.7% did not know how they could share their feedback. Of the 48 facilities observed, only 42% had suggestion boxes. Interviews with facility in-charges revealed that where the suggestion boxes are present, they are hardly used, as most clients seem to prefer to share their feedback in person with a member of staff. The minimal use of the suggestion boxes could be because the clients do not understand its purpose, or their literacy levels, or the lack of the writing material (pen and paper) next to the suggestion boxes. The client understanding of feedback also indicates that the suggestion boxes are often seen only as a forum to lodge complaints.

Most clients have not understood the value of both positive and negative feedback in informing the facilities on the quality of services provided.
It is useful to invest in education on health rights, principles of public service and ethics at the community level so that community members can be more proactive participants in the design and delivery of healthcare and demand for more from their health facilities.

The Kitui County Health Facilities Management Committees Bill 2014 attempts to strengthen the participation of the community in delivery and monitoring of health services by providing for the appointment of a Health Facility Management Committee. The recommended membership of the Committee is varied and appears to be inclusive. It provides for the inclusion of a representative of women, faith based organizations, the youth, and persons with disability, among others.

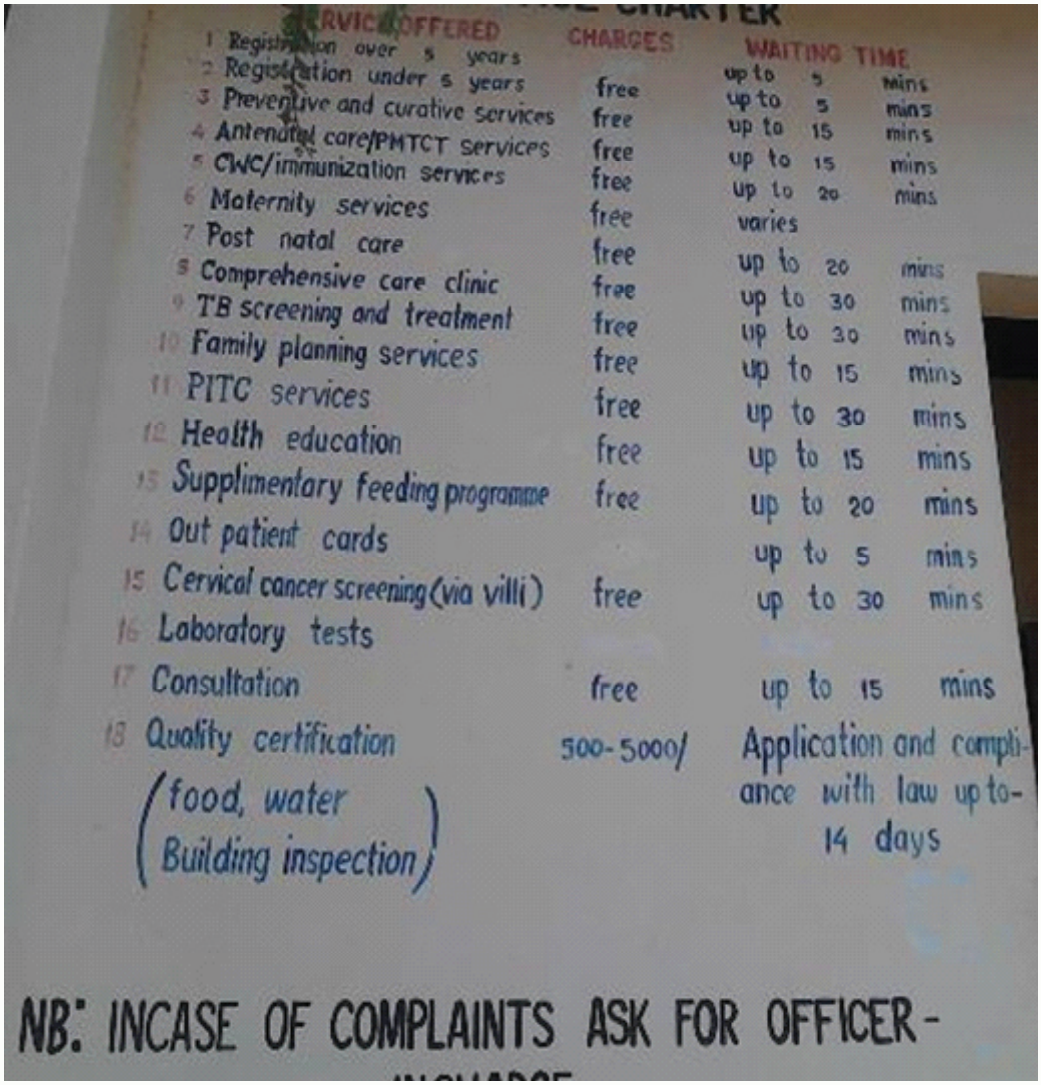
The role of the community in the selection of committee members can be strengthened by allowing greater participation by the community in this process. Involvement of the community in selecting its representatives has already been modelled in the Community Strategy, in which the community members play a key role in choosing the Community Health Workers as well as the members of the Community Health Committee for the Community Unit. When the community members are fully engaged in the selection of their representatives, it makes it easier for them to demand for and get accountability from the persons they have chosen to represent them.

3.4.4 Service Charters

The concept of publicly displayed service charters for health service delivery was a product of the series of reforms instituted in the civil service in 2003 to improve service delivery in all sectors[29]. The health services charter defined the 'mandate, commitments and obligations' to users of the services. It was intended as information mainly for the clients. The concept of a health service charter is based on the principle that a shared understanding of the rights of patients and the quality of care expected from a health facility promotes the overall standards of health care delivery. Service charters therefore build on the concept of providing information to facilitate informed consent, access to services, and participation, and to publicly communicate the standards of service to which a facility is committed and to promote a culture of accountability of the service providers to the service users.

29 See, Ministry of Health Service Charter for Health Services Delivery, December 2006. pp.2-3

Nature of the Health Facility Service Charters

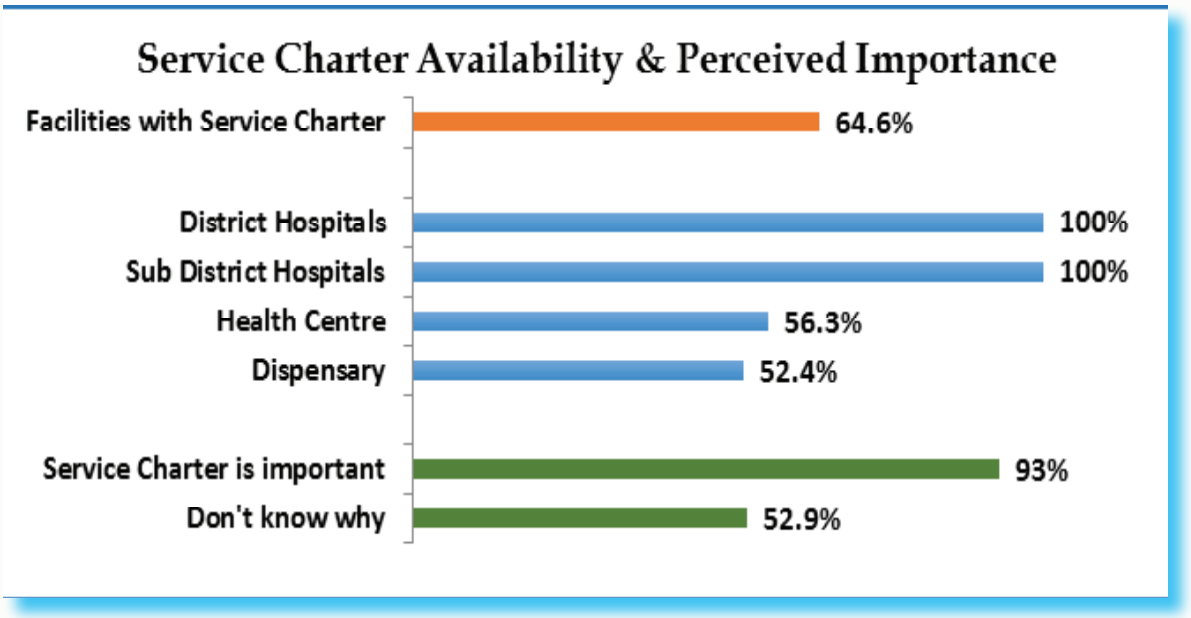


Although the Ministry had developed a comprehensive charter on services provided and the quality provided, the shorter versions displayed in health facilities currently list the services offered in the facility, the duration of the service, and the costs of the services.

In many cases, the Service Charters are painted onto an external wall of the health facility building or onto a signboard at the entrance (gate). Where permanent notices were unavailable, creativity and determination was demonstrated in some facilities that used flipchart papers written out and pinned up, detailing the services available and the costs. While the study already indicates that not many patients will rely on the signs, it is important nonetheless to ensure adequate signage and information,

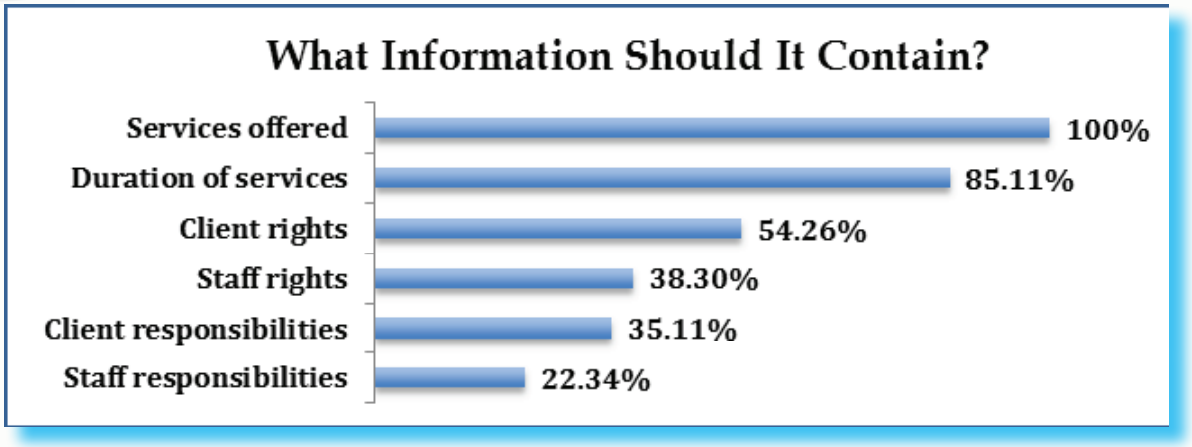
while complementing the written methods with other oral methods, such as having a customer care desk or enquiries desk, audio provision of information, among others.

Staff Understanding of the Service Charter



Based on the observations made in the 48 facilities, 64.58% of the facilities were found to have a clear sign showing the Service Charter. Interviews with staff established that 93% of the staff felt that the Service Charter is important, but up to 53% are unclear on what specific aspects make it an important tool in health service delivery. This could be an indication that the staffs has not been adequately educated on the importance of a Service Charter, and they therefore simply comply with the requirement to have the Service Charters displayed in the facility.

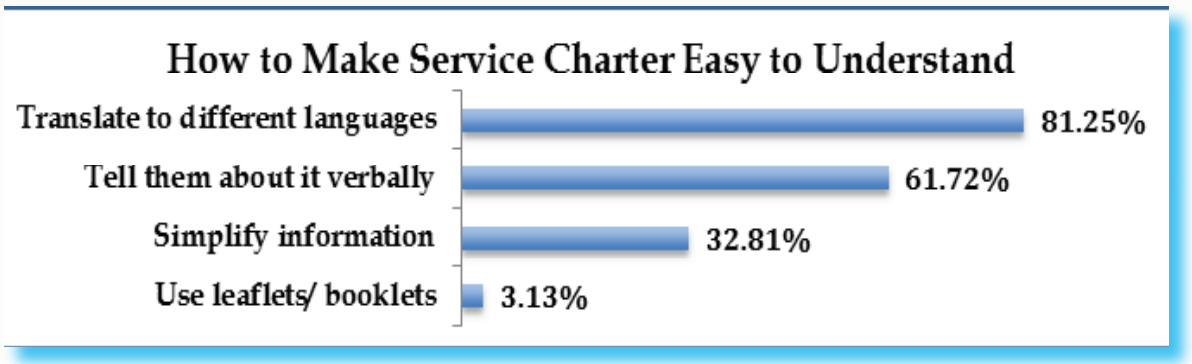
When asked what information should be contained in the Service Charters, all the staff felt that it should contain the services offered at the facility and 85.11% thought it should include the duration of services. This mirrors the current standard practice countrywide based on interpretations of directives given by the Ministry of Health in 2006. In addition to the services offered and the duration, a further 54.26% felt it should include client rights, 38.3% recommended the inclusion of staff rights, 35.1% client responsibilities, and 22.3% staff responsibilities.



Clarity of Service Charters

A core aspect of a service charter is that it must be able to communicate to the service users and service providers, and provide essential information. In an attempt to make the Charters easier for clients to understand, a number of the facilities have written them in English as well as vernacular. While this effort is commendable, it must be noted that where a person cannot read and write, any written signs and notices will not be an effective means of communication.

It was also noted that some of the Charters used formal medical terminology to describe the services offered, which may not be understandable to the clients. In fact, 71.28% of the staff from the facilities that have a Service Charter felt that the Service Charter is not understood by all the clients. To make it easier for the clients to understand it, 81.3% of the staff suggested that it should be translated to different languages, 61.7% felt it should be communicated verbally, and 32.8% felt the information in Service Charters should be simplified.



While making decisions about the approaches to use to communicate the Service Charter, the Ministry of Health and Sanitation in Kitui County should pay attention to the fact that none of the clients seem to use the written signs to obtain information about the services, and instead seem to rely on verbal communication with staff and other clients. In this regard, communication of the Service Charter and other important health care and health facility information should draw from the fact that oral media also has a part to play in communicating information to clients. This could include use of customer care desks, announcements in health facilities through public address systems or pre-recorded audio messages; externally through public forums such as barazas, services held in religious institutions, radio where possible, among others.

The study indicated that majority of the patients (55%) get information on services by communicating orally (asking staff or other patients) and very few rely on the Charter. As such, the information provided in the charter should detail standards that the hospital is setting based on standards expected within a rights-based approach. Communication of other important information should be done in a variety of ways: for example,

Important elements of Service Charters

- The Service Charter should communicate the ethos (culture) of the health facility and the commitments to quality it is making. In this regard, information on clients' rights and responsibilities, the guiding principles, as well as the vision and mission of the facility are important to have in the Service Charter.
- The Charter that is pinned up for public display should be succinct and easy to read. In addition, the language used should be easily understandable to non-medical personnel. The physical presentation (layout) should also be given consideration as it determines whether people are drawn to read the charter or not.
- The Charter should be displayed (or announced) in a place where clients can engage with it at leisure, for example, in waiting areas.
- The Service Charter may not be the best way to communicate the services available and their costs. While most clients prefer to receive verbal information, this does not negate the importance of having notices and signs indicating the costs of services. These can be displayed separately from the Service Charter in strategic locations at the various service delivery points (e.g. the laboratory for lab services).
- The Service Charter is a living document that should be communicated to and understood by the staff and clients of health facilities. It should form a critical part of the dialogue between the health facilities and the community on the degree to which the rights of clients are being

fulfilled. Regular review of the achievement of the commitments within the Charter should be conducted jointly and the Charter should also be updated to reflect progress in the achievement of the rights based approach to health service delivery.

4.0 Conclusions and Recommendations

Kitui County has made important strides in improving accessibility, availability, acceptability and quality of healthcare services. There are specific programs that have been commenced towards strengthening preventive measures, including environmental cleanliness and sanitation in communities, community health discussions, among others. The County management is also aware of the particular challenges faced, including the related development challenges of roads and infrastructure, water scarcity, poverty and education levels. These issues have been prioritized in the County Integrated Development Plan (CIDP). There is room for further initiatives based on a rights-based approach to address the gaps that the study reveals. The key challenges for the County towards the realization of a rights based approach to health service delivery are related to the inequitable distribution of health facilities, the critical shortage of staff, and the inconsistency and inadequacy of drugs and supplies.

The elements of implementing a rights based approach in health care and ultimately improving health service delivery are neither distinct nor separate. Measures taken to improve one aspect of health service delivery, such as availability, are bound to have an impact on accessibility, acceptability and quality. The recommendations below therefore summarize measures that would strengthen rights based approaches to health care in Kitui County based on the findings of the study.

4.1 Actions for strengthening the rights-based approach

1. **Improve on the equitable distribution of health services:**
   This study established that some of the Wards within the County have more than the minimum recommended number of health facilities while others had less than the recommended number. This introduces inequity in the distribution of health services, which puts some citizens at a greater disadvantage and makes it more difficult for them to access the health services. To address this inequity, the County needs to reassess the distribution of health facilities on the basis of population density and the maximum distance that needs to be covered especially for facilities performing Level 3 functions. In line with the principle of progressive realization, the guidelines provided in the Norms and Standards for Health Service Delivery can form the basis for this decision, and once these

recommendations have been achieved, international standards can then be pursued. Redistribution of health facilities to improve on equity may necessitate temporary closure of some of the currently functional facilities, upgrading of others, and construction of new ones. Dialogue with the community members and their leaders is likely to make the decisions made regarding the redistribution of the health facilities more acceptable to the community and therefore minimize any potential resistance.

In addition, health facilities should build capacity to use the data they gather from the client data cards in order to determine the categories of clients who seek healthcare, the health issues they may have, and the periods when specific categories visit health facilities. These would enable facilities in prioritizing preventive and curative services for the population within the vicinity of the facilities.

2. Improve the infrastructure of health facilities:

Laboratory services, provision of adequate drugs and supplies, and increased staffing levels were the top 3 aspects of health service delivery recommended for improvement, by both clients and staff. It may be necessary to reassess the current outfitting of the health facilities in order to bring the most essential services closer to the community. For instance, the dispensaries currently do not currently have laboratory services and have minimal or no provisions for performing normal deliveries. Yet dispensaries are the most accessible of the health facilities, within the health delivery system. If dispensaries are equipped with a basic laboratory that can perform the tests required for the ANC profile, and are provided some space in which to conduct deliveries, this would increase accessibility to health service to majority of the population and minimize the distances that they would need to travel. Similarly, the dispensaries should be equipped very well and have the necessary management systems functioning well in order to address all common ailments at the initial stages. This may mean that the current categorisation of levels of facilities by typed of services and prescribed number of staffing levels may need to be revised with the focus changing to the needs of the services required for the people seeking health. It does not for instance make sense for one to go 5 km to a facility to be told to go another 5 or more KM to another facility to get laboratory tests before returning back to the 1st facility for treatment.

This recommendation needs to be considered together with the need for additional staffing in 3 below to support the delivery of the required health services.

3. **Improve on the staffing levels:**

The findings of this study established that the Kitui County health delivery system is operating at 28% of the required staff establishment. Nurses, who should form the bulk of the service delivery team, are currently only 36% of the minimum number required. The ability of the staff to deliver services that adhere to the tenets of the rights-based approach is severely compromised by the current insufficient staffing levels. Staffing levels have a direct impact on the availability of health services, continuity of care, the waiting times, and overall quality of health services. The staffing levels need to be increased to ensure staff are working at optimal levels or as close as possible to optimal levels. Given that the health sector is a service industry, it is conceivable and inevitable that a significant portion of the costs for the delivery of services will be taken up by the personal emoluments. The national Assembly, Senate and Commission on Revenue Allocation (in determining the equitable share of the national revenue between the two levels of government) and the County government (the executive and the County Assemblies in determining the health sector budget) may need to explore creative approaches to increase the budgetary allocation to the health sector to support the recruitment and retention of additional staff at the county government level. The determination of the number of staff per facility should not be a general standard that does not take into account the traffic of clients visiting any facility for services. A dispensary in one location may, for instance have a greater traffic of even up to 2 or 3 times more clients than the other. A standard that suggests that both should have the same number of staff merely because they are both dispensaries will clearly disadvantage one of the facilities.

4. **Improve on Level 1 health service delivery and communication with the community:**

Delivery of health services should begin from the community level with basic preventive and promotive healthcare, and then progress all the way to the county referral facilities that should offer more advanced care, at the county government level. The Community Strategy developed in by the Ministry of health as an approach that can be used to deliver community level health services using a network of community-selected Community Health Workers should be operationalised by Kitui County. Whereas the principle of progressive realization recognizes that resource limitations may make it difficult to fulfil the total package of community health to ensure fulfilment of the obligations to meet the right to health, it is important to note the greater value that community health education

will add to facility based health service delivery by reducing the number of cases that go to facilities which would be averted by this strategy. With this in mind, steady progress can be made through the implementation of transitional strategies that take into account available resources while ensuring continuous improvement towards implementation of the Community Strategy as recommended. In this regard, the County should invest in and put systems in place to educate the community members on preventive and promotive health, develop a policy on how it plans to progressively realise the right and health services should be provided as a priority in the early days at each health facility.

Given the minimal reliance by clients on written media, the written forms of health messages should be complemented with verbal communication in various languages, including indigenous, Sign language and other communication formats and technologies. For instance, the use of 'Customer Care Desks' may be a better option than relying on the use of signs and posters which are not widely read or understood. Non-medical can be given basic training on basic appreciation of health care services to provide support in man guiding clients and responding to the frequently asked questions and provide directions. In addition to this, facilities can prepare pre-recorded multi-language messages for announcement to be aired within the facilities, vernacular radio & TV programs. Chiefs' barazas, religious gatherings, citizens' fora, and schools, among others, can also be used to pass important messages about preventive and promotive health as well as the minimum standards of healthcare and the Service Charter.

5. Review and more carefully define the cost of healthcare:

Delivery of health services is a resource-intensive endeavor that requires adequate financial resources. Insufficient financing of health services makes it difficult to meet the minimal requirements that can ensure that the right to health is respected, promoted, and fulfilled. The financing of health services can be done in various ways, including from government funding, pre-payment, risk pooling and other mechanisms to minimize out-of-pocket payments, and the collection of user fees, taking care that these fees do not lead to the impoverishment of the clients.

Currently, the costs of health services in Kitui County range from free to KES 30 for consultation. In addition to this, the client may be required to incur additional costs related to diagnostic tests and provision of drugs, apart from the indirect costs like transport to

the facility and loss of income while at the facility. The County should review the pros and cons of this fee structure and whether low to nil payments in the context of the current health financing mechanisms have contributed to enhancing or diminishing the quality of healthcare services. If the health system is unable to sustain a minimum standard of health services while adhering to the current fee structure, there should be dialogue with the community and the leaders to agree on a more tenable structure. It is possible that the current fee structure introduces out-of-pocket expenses for the clients that make the cost of healthcare even more expensive for clients than it would be if the fees were slightly increased to allow the health delivery system to procure more of the resources required to efficiently deliver the health services. If fees are increased and quality of services, drugs and supplies is improved and guaranteed, it is conceivable that individuals will feel that they are receiving value for money.

The County can also explore the role of health insurance schemes as a way to minimize the burden of healthcare to the community. For instance, the County can partner with the health insurance providers like the NHIF to hold awareness campaigns across the county to prompt more people to use the of insurance like NHIF healthcare management system to reduce individual cash costs of medical care, particularly for in-patient costs.

6. Improve provision of water to health facilities:

Based on the findings from the study, many facilities have challenges accessing adequate supply of water, whether for cleaning, drinking, hand-washing, or ablutions. The right to clean water is one of the rights inter-related to the delivery of the right to health. Access to water is a basic need in health facilities and is extremely useful in supporting infection control measures and implementation of standard precautions. The County therefore needs to ensure that its development plan on rights that inter-relate to the delivery on the right to health is harmonised with the plan on the development of health facilities to ensure that the facilities can access adequate supply of clean, safe, potable water as an essential infrastructural aspect of the right to health. The Kitui County Integrated Development Plan 2013 – 2017 is an important platform that demonstrates the interconnectedness of social welfare services in improving the overall health and wealth of communities in the County. Intra-sectoral discussions at the County Government level (should scale up the discussion with the departments responsible for ensuring access to water.

Enabling environment for health service delivery:

More than 80% of the clients interviewed would choose to go to a public health facility before seeking any other kind of intervention. However, this could be because the services are considered less expensive and widespread. The wide reach of the public health facilities is an important aspect in realizing the right to health. However, the current service standards do not yet fully realize the requirements of the rights based approach to health service delivery. To support the realization of the rights based approach to health and the commitments embodied in the Service Charter, the County Department of Health should invest in the improvement of the working environment, including the provision of adequate space, supplies, equipment, and other amenities. A paradigm shift that focuses on quality healthcare services in public institutions will in the long run reduce the costs of health care and increase confidence in public institutions.

7. Develop a county legal and policy framework for health:

Legal and policy frameworks are necessary to ensure an overarching structure within which all the components of the health sector operate. A policy framework provides the blueprint for engagement within the health sector and externally with other sectors and actors. A legislative framework gives the health sector in the county legal mandate for their approach and direction. Policy and Legal frameworks will also ensure that Kitui County can ensure its health sector approaches are in line with the Constitution. It will be an important step for the County to prioritize enactment of enabling County health legislation and attendant health policies. The policies and laws should be aligned with the Constitutional provisions on the right to health, the right to the highest attainable standard of health, the right to emergency treatment and the right to information; and values and principles in the constitution. The policies and laws should also provide information on the plan on the necessary pillars for effective delivery by health systems including County leadership and governance in the health sector, county health financing; human resources; County health infrastructure; health products, commodities and technologies; County health information systems and strategic partnerships.

4.2 Media and Communication

As the study demonstrated, there is little use of media as a tool for communication on community health issues and on health services available within the facilities. Health care workers also expressed concern that the media often focuses on portraying the sector negatively. Media professionals on the other hand pointed out that the health sector is often highly secretive and unwilling to provide information particularly when incidents arise. Ultimately, the poor use of media to communicate on health services undermines access to services for community members.

Healthcare workers and media and civil society, together or separately, have a duty to empower health service clients. It is important for partnerships between the media and the health sector for communication to the broader public to be anchored in a genuine desire to share information truthfully and accurately. For better clarity, those providing information need to provide contextual background while demonstrating linkages between the various issues being highlighted. The following are some of the recommendations on the use of media and communication strategies to increase awareness among the community and to support the realization of the rights-based approach to health service delivery:

1. the medium to be used should be friendly to the community
2. use media with the widest public outreach in the county which include- television stations, information communication technology centres, websites, community radio stations, public meetings and traditional recognized media.
3. Share consistent and regular stories on the successes of the rights based approach in national and local media as well as through Barazas
4. Media input – push for branded segments in either electronic or print media on the rights based approach to health services delivery. Media can be convinced to buy in and give airtime and print space for the health services (for free)
5. Seek partnerships with donors and other interested stakeholders for the support of regular and syndicated columns on the rights based approach to health service delivery
6. Use new technology such as SMS, Facebook, Twitter, WhatsApp, etc. These can be used to conduct brief surveys on experiences with a particular health facility, to communicate on schedules (e.g. on Thursday we open at 11am), or to remind clients about a follow-up

appointment that's almost due. SMS could be used to enhance trust in services delivered at a health facility through targeted messages, for instance, a welcome message to a client visiting a facility or an exit interview with a client upon departure from a facility

7. Innovation in the use of the public address system and information boards, including electronic boards. Up to date announcements could be made through the public address system or a scroll at the bottom of the screen of an electronic board in the event there is critical information requiring communication, for instance, on availability of consultancy services at a facility on a given day or in the event of a delay in the delivery of certain services

4.3 Service Charter Recommendations

The study found that in nearly all the facilities, the Service Charters were displayed as notices summarizing the services available, the cost of the services and in some cases, the length of time for the services. None of the facilities assessed had service charters that articulated the rights of clients and the standards of service that the facility was committed to providing.

The Service Charter is a statement of an organization's commitment or promise to its clients. It communicates the standards of service that the clients of the organization should expect to receive as well as what the clients need to do to facilitate the delivery of this standard of service. In this regard, the following recommendations are made regarding the health service charters for Kitui County:

1. **Content of the Service Charter:**
   The Service Charter should focus on communicating the rights and responsibilities of the clients. The list of services and the charges should be displayed nearer the service delivery points as a separate poster/ sign and need not necessarily be part of the service charter. The Charter may include specific commitments on improving physical access for persons with disabilities, elderly persons and other population groups that are identified to have specific challenges with physical access to the health facilities. The Service Charter should also inform clients where to go for help if they have concerns about the service that they are seeking or receiving. To increase authenticity, the service charter should be embossed with the county logo and dated. The Charter should be available in a short version to be pinned up and a longer version that provides further details in the booklet.

2. **Communication of the Service Charter to staff:**
   To ensure that the ethos represented in the Service Charter is embodied by all staff, deliberate efforts in the continuous education of all health workers must be made. This can be done through multiple channels such as brochures, posters, during staff meetings, and as part of an induction process for new staff..

3. **Communication of the Service Charter to clients:**
   To ensure that all clients including those with visual and hearing impairment have access to and comprehend the information contained in the Service Charter, the content should be simple, expressed both in print and audio versions and be available in the different languages used in the County and other communication formats. The Charter should be pinned up where clients can read it at leisure, and staff can see it as they continue their services, for example in waiting areas.

4. **The Service Charter as a quality management tool**
   Apart from making the Service Charter a part of the performance management system for individual members of staff, health facilities should also undertake regular assessments of the implementation of the Service Charter together with the Facility Committee and the community members. These dialogues around the Charter should encourage the celebration of achievements as well as the identification and resolution of challenges to adhering to the commitments contained in the Charter.

Two versions of a Service Charter – a comprehensive and abridged version – have been developed based on evidence obtained from document review and consultation with clients, health service providers and public health officials in Kitui County. However, we recommend that the county government refines it to fit its needs and each health facility tunes it to its specific needs, while retaining the general latter and spirit of article 10. The service charter views health service provision as a partnership between service providers and clients. Under this partnership, the service providers, as duty bearers to the right to health, have certain obligations / responsibilities while the clients, as the rights holders, have certain rights and responsibilities for their own health care. The proposed service charter builds upon many of the provisions of the National Patients' Rights Charter (2013) and expounds on the specific commitments that the health facilities can adopt in order to promote and fulfil the rights of the clients. The contents of the proposed service charters may spark questions, comments and clarifications from clients. Service providers should not be afraid and should welcome this conversation and be prepared to answer questions and address the issues clients raised. Below is the abridged version.

County Government of Kitui
Ministry of Health and Sanitation
WELCOME TO [Facility Name, Sub-County]

Health Service Patient Charter

YOUR RIGHTS	YOUR RESPONSIBILITIES
To receive appropriate, timely health care, including emergency treatment, without discrimination.	To follow and abide by the health facility's policies, regulations and processes, and to complete any forms as required.
To be attended to in an equal manner without regard to your status including Gender, Disability, Age, Health Status, Religion or membership to a minority or other special group.	To follow the first-come first-served system regardless of your social, political or other status unless your case warrants to be fast-tracked.
To receive the highest attainable quality of health care that does not expose you to unnecessary harm; and to be served by qualified identifiable health care professionals and authorized staff in uniform.	To treat health care professionals, authorized staff and other clients with respect and dignity.
To be served courteously, compassionately, and with respect.	To provide the health care professionals with accurate information about your health and to ask for clarification about what you do not understand.
To the right to freedom from torture, cruel, inhuman and degrading treatment while under the care of the health care facility.	To follow the prescribed treatments, rehabilitative procedures and follow-up care.
To be served in a way that respects your privacy and right to confidentiality.	To sign against your decision to decline any treatment recommended by the health facility.
To the right to bodily integrity and security of your person while under the care of health care facility.	To make payments only for services that require authorized payment and obtain official receipts, and to inform management of any irregularities.
To continuity of services, referral, follow up and advice necessary for your health care.	
To be provided with clear, appropriate, timely, and understandable information about your health and health care and the facility policies, regulations and operational protocols.	
To be involved in making informed decisions and choices about your health care including the right to a second opinion.	
To decline to receive treatment.	
To clear and transparent information on the services that are provided free of charge and the costs of the paid services at the health facility.	**Hours of Operation:** **Monday – Friday: Indicate Time** **Saturday & Sunday: Indicate Time**
To a clean and safe environment within the health facility.	**Public Holidays: Indicate Time**
To freely express your complements, comments and complaints about the health care you receive. On the submission of complaints- we promise to subject your complaint to a fair and due administrative process for yourself and any person involved in the matter.	**Our Contacts:** **Facility Name** **Emergency Telephone Contacts** **Feedback Contact**

Appendices

NB – Due to volume of the appendices 3 – 10, they are attached as a separate document.

Appendix 1: Health Facilities Participating in the Study – Kitui County
Appendix 2: List of Law and Policy Frameworks Reviewed
Appendix 3 Client Interview Guide
Appendix 4: Health Facility Staff Interview Guide
Appendix 5: Health Facility In-Charge Interview Guide
Appendix 6: Focus Group Discussion Guide
Appendix 7: Health Facility Observation Guide
Appendix 8: Key Informant Interview Guide
Appendix 9: Document Review Guide
Appendix 10: Consent to Photograph, Video, or Record Form
Appendix 11-1: Draft Kitui County Health Service Charter – Brief Version 1
Appendix 11-2: Draft Kitui County Health Service Charter – Expounded Version

Appendix – Health Facilities Participating in the Study in Kitui County

Sub-county	Ward	Hospitals	H. Centres	Dispensaries
Kitui Central	Township	Kitui DH		
	Miambani		Miambani	
	Kyangwithya East			Kasyala
	Kyangwithya West			Tungutu
	Mulango	Katulani SDH		Wii
		2	1	3
Kitui Rural	Kanyangi	Kanyangi SDH		
	Yatta/Kwavonza		Yatta	Muselele
	Kisasi			Kisasi; Mbusyani
	Mbitini		Mbitini	
		1	2	3
Kitui West	Kauwi	Kauwi SDH		Kiseveni
	Mutonguni			Tulia; Kakeani
	Kwamutonga/ Kithumula			Kwa Mutonga
	Matinyani			Matinyani
		1	0	5
Kitui East	Nzambani		Yanzuu	
	Chuluni			Katumbu
	Zombe/Mwitika			Kasunguni; Inyuu
	Endau/Malalani			
	Kyamatu/Voo		Voo	
	Mutito/Kaliku	Mutito SDH		
		1	2	3
Kitui South	Ikanga/Kyatune	Ikanga SDH		
	Mutomo/Kibwea		Mutomo	
	Mutha/Mathima		Mutha	
	Ikutha		Ikutha	
	Athi			Ilengi
	Kanziku			Mikongooni
		1	3	2
Mwingi Central	Kivou/Enziu			Kanzui
	Mwingi Central	Mwingi DH		
	Waita/Endui		Waita	
	Nguni		Nguni	
	Mui			Mui
	Nuu	Nuu SDH		
		2	2	2

Mwingi West	Kiomo/Kyethani		Kyethani	Itong'olani
	Kyome/Thaana		Thitani	Thaana Nzau
	Migwani	Migwani SDH		
	Nguutani		Nzawa	
		1	3	2
Mwingi North	Tseikuru	Tseikuru SDH		
	Kyuso	Kyuso DH		
	Ngomeni		Ngomeni	Tii
	Tharaka		Tharaka	
	Mumoni		Katse	
		2	3	1
Total	**48 facilities**	**11**	**16**	**21**

Appendix 2 – Legal and Policy Frameworks Reviewed

1. Constitution of Kenya 2010
2. Kenya Vision 2030
3. Kenya Health Policy 2014–2030
4. Kitui County Health Facilities Management Committees Bill 2013
5. Kitui County Integrated Development Plan, 2013-2017
6. Kenya Health Sector Strategic and Investment Plan (KHSSP) July 2014 – June 2018
7. Health Service Delivery Charter
8. The Kenya National Patients' Rights Charter, 2013
9. Kenya Health Sector Referral Strategy, 2014-2018
10. Kenya Health Sector Referral Implementation Guidelines 2014
11. National Reproductive Health Strategy, 2009-2015
12. National RH & HIV/ AIDS Integration Strategy, 2009
13. Reproductive Health Communication Strategy 2010-2012
14. National Guidelines for HIV Testing and Counselling in Kenya, 2010
15. National Guidelines on Management of Sexual Violence in Kenya, 2009
16. National Guidelines for HIV/STI Programs for Sex Workers, 2010
17. Standards for Peer-Education and Outreach Programs for Sex Workers, 2010
18. National Guidelines for HIV/STI Programming With Key Populations, 2014
19. Community Strategy – Taking the Kenya Essential Package for Health (KEPH) to the Community
20. Community Strategy Implementation Guide

Integrating Constitutional Values and Principles and the Rights Based Approach in the Operational Frameworks of County Health Care Facilities

2015

County Government of Kitui
PO Box 460-90200, Kitui

Ministry of Health and Sanitation

EMBASSY OF DENMARK
DANIDA | INTERNATIONAL DEVELOPMENT COOPERATION

Commission for the Implementation of the Constitution
Utekelezaji wa katiba, jukumu la wote