County Government of Nyeri

DEPARTMENT OF HEALTH SERVICES

Health Facilities Assessment Report

EMBASSY OF DENMARK

DANIDA | INTERNATIONAL DEVELOPMENT COOPERATION

Commission for the Implementation of the Constitution

Utekelezaji wa katiba, jukumu la wote

Integration of Constitutional Values and Principles and the Rights Based Approach into Health Service Delivery

Report of the Assessment of Nyeri County Health Facilities

Submitted by:
The Commission for the Implementation of the Constitution (CIC)
20 November 2015

PREFACE

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 monitoring, facilitating and overseeing the development of legislation and administrative procedures required for the implementation of the Constitution, and overseeing the effective implementation of the devolved system of Government.

CIC has undertaken a number of activities with the national and County Governments, including the formulation and review of policies, legislation and administrative procedures that facilitate the implementation of the constitution. As part of its facilitative mandate, CIC in collaboration with the County Government of Nyeri undertook a project of evaluating the operational frameworks of the health facilities in Nyeri County. The purpose was to identify ways of ensuring the county complies with its constitutional mandate, by putting in place the mechanisms necessary for guaranteeing the respect, protection, promotion and fulfillment of the fundamental rights and freedoms, and the national values and principles enshrined in the Constitution and international human rights instruments ratified by Kenya.

The project was largely triggered by frequent media reports on the mistreatment of patients seeking health care services in different public health facilities around the country. Various forms of human rights violations have been reported, including physical and verbal abuse, mistreatment and harassment, neglect and abandonment, denial of admission to facilities, humiliation, punishment and detention of patients in health facilities for failure to pay hospital bills, among others. The key objectives of the project were to:

(i) Review the operational frameworks and work culture in the county health facilities against the constitutional requirements, and make recommendations on what can be done to entrench a work culture that is compliant with the values and principles of the constitution

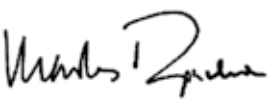
(ii) Review and align the county health facility service delivery charters with the constitution, and

(iii) Develop 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 process of this project was also documented to facilitate learning for others. The project was supported by the Danish International Development Agency (DANIDA).

This report is a summary of the project activities and the findings are intended to provide some general guidance to the Nyeri County health service providers in the public sector as they embark on their task to implement their constitutional responsibilities on the right to health, and the integration of national values and principles in health service delivery in county health facilities.

It is the hope of CIC that the County Government of Nyeri will implement the recommendations of the report and continually endeavor to improve service delivery in their health facilities.



Mr. Charles A. Nyachae

Chairperson

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Acronyms

ACHPR	Africa Charter on Human and People's Rights Against Women
CBO	Community Based Organisation
CDF	Constituency Development Fund
CEDAW	Convention on the Elimination of All forms of Discrimination againt Women
CERD	Convention on Elimination of all forms of Racial Discrimination
CIC	Commission for the Implementation of the Constitution
CRC	Convention on the Rights of the Child
FBO	Faith Based Organisation
FDI	Foreign Direct Investment
FGD	Focussed Group Discussion
GDP	Gross Domestic Product
ICESCR	International Convention on Economic Social and Cultural Rights
ICPD	International Conference on Population and Development:
ICT	Information and Communication Technology
KELIN	Kenya Legal and Ethical Issues Network
NGEC	National Gender and Equality Commission
NGOs	Non-Governmental Organisations
PLWHA	People Living with HIV/AIDS
PWD	Persons with Disabilities
RBA	Rights Based Approach
UDHR	Universal Declaration of Human Rights

Acknowledgements

This report on Integrating the Rights Based Approach and other Constitutional values and principles in the Institutional Operational Frameworks in Health Care Facilities in Nyeri County is a result of concerted efforts of many individuals and stakeholders. The Commission for the Implementation of the Constitution (CIC) wishes to acknowledge all those who were involved in one way or another in the development of this report:

We particularly thank CIC Commissioner Catherine Mumma and Christine Njeru for overseeing the project and guiding the entire process from concept note, briefing of consultants, training on the Constitution and the rights based approach to service delivery, development of tools, coordination with the consultants and county team including the recruitment and training of data collectors, national and county workshops, data collection, analysis report writing and developing the service charters. Appreciation is also extended to the other officers who supported the project including James Wagala, Ruth Muthui, Ahmed Anwar, and Veronica Omunga for the administrative support.

The expertise and commitment of the team of six data collectors from Nyeri County namely Alex Maina, Everlyne Ngunjiri, Winny Gitonga, Patrick Wagura, Charles Murage and Nicholas Saba is acknowledged.

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

The electronic data management and research services provided by the Bon Sante Consulting team led by Michael Kirui with the inputs of Mukhaye Barasa, Delilah Chepkonga and Eunice Were are acknowledged.

Appreciation is extended for the collective efforts of the project team of consultants comprising Dr. Ruth Aura and Dr. Kennedy Manyonyi (Bungoma County), Eva Maina Ayiera and Carol Nyambura (Kitui County), Professor Patricia Kameri-Mbote and Dr. Betty Chirchir (Nyeri County) the human rights and public health consultants who coordinated the data collection, analysis and report writing in assigned counties.

Gratitude is extended to DANIDA for their financial and technical support, which facilitated the whole process.

The contributions of the oversight committee at the national level consisting 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 Media representative and the Nyeri County project oversight committee (consisting of representatives from County Government) and all stakeholders who participated in the regional and national workshops and data collection exercise are acknowledged. The stakeholders included doctors, clinical officers, nurses, laboratory technologists, counsellors, public health officers, community members, media, development partners and representatives of nonGovernmental organisations (NGOs), faith-based organisations (FBOs) and community-based organisations (CBOs).

Executive Summary

The Commission for the Implementation of the Constitution (CIC) is mandated to monitor, facilitate and oversee the implementation of the constitution as well as to effectively monitor the system of devolved Government. Whereas the Constitution, which was promulgated in the year 2010, has entrenched key values and principles under Article 10 including public participation, inclusiveness, equality, non-discrimination, transparency and accountability, the extent to which these values and principles have been integrated in the operational frameworks of county health service delivery has not been assessed. CIC in partnership with the counties of Bungoma, Nyeri and Kitui, and with the support of the Danish International Development Agency (DANIDA), initiated a project on integrating constitutional values and principles, particularly those in Article 10 of the Constitution of Kenya 2010 (which include the rights based approach to service delivery) into operational frameworks and work culture of health care facilities in three pilot counties: Bungoma, Kitui and Nyeri.

The project aimed at examining existing operational and management frameworks and systems for county health facility services, to assess their compliance with the Constitution, and in particular with Article 10, and making recommendations on improvements to ensure integration of constitutional values and principles. The project also aimed at analysing the health facility service charters against the Constitution, and to revise them accordingly. Noting that ratified international treaties are now part of the laws of Kenya in line with Article 2 of the Constitution, the project adopted the international indicators developed by the Committee of the United Nation's Covenant on Economic, Social and Cultural Rights in General Comment No. 14 on the right to health which are: availability, accessibility, acceptability and quality (AAAQ), for measuring the delivery of health services to citizens and residents.

The short-term results expected of the project were rights based county health facility charters that are 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 where service providers operate in an environment that enhances their outputs, while respecting their rights.

This report presents the background and context, methods, findings, conclusions and recommendations from the review of the operational and administrative frameworks in integrating the constitutional values and principles in health service delivery in Nyeri County health facilities. It also presents a health service charter that is compliant with the Constitution. The charter was developed based on the findings of the assessment, and dialogue with stakeholders.

Methodology

The project utilized a participatory and capacity building approach. Rights based and public health consultants worked in consultation with CIC, a national oversight team and county health teams to:

1. Train all participating stakeholders on the Constitution, health as a devolved function, the right to health and the rights based approach to service delivery

2. (ii) Review the current operational frameworks for service delivery in the county health facilities

3. Conduct a cross sectional survey through which data was collected using quantitative and qualitative methods and

4. (iv) Integrate the values and principles of the Constitution and the rights based approach into the Nyeri County health facility service charters.

The survey covered a sample of 26 health facilities in five levels of health care in all the eight sub-counties of Nyeri County. Information was collected through document review, client exit interviews, health workers interviews, health facility observations, focus group discussions with community members and key informant interviews. A total of 198 clients accessing health services and 112 health workers were interviewed. At the county level, ten key informants were interviewed. Key informants at the facility level comprised 26 officers in charge of the health facility. Six focus group discussions were held with persons with disabilities, women, people living with HIV, jua kali workers, sex workers and community health volunteers. Information on the operational frameworks, and the qualitative and quantitative data collected were compiled and analyzed in order to understand the current situation and make recommendations for improvement of the service delivery. The data were analysed using a rights based approach and centred on four elements of the right to health: availability, accessibility, acceptability and quality.

Findings

- A review of the operational frameworks revealed that Nyeri County is utilizing health policies and guidelines developed both at national and county level, the majority having been developed prior to the 2010 Constitution. The County operates according to operational guidelines and frameworks, some of whose tenets are written while others are not. Complete transition to county level operational frameworks, policies and guidelines is yet to be achieved.

- Most of the service delivery policies and guidelines were developed by the National Government. Since the new Constitution was put in place, the County has developed an elaborate health services strategic plan, health policy and a law on health – the Nyeri County Health Act (2015), which seeks to implement the Constitutional provisions specially Article 10 and Article 43. A budget framework has been developed and plans are in place to have a level 4 hospital in each sub-county. Nyeri County is on the right track towards the attainment of the right to health for its residents. It is critical that the County focuses on finding ways and means of availing resources for implementation of the policies, guidelines, plans and strategies

Health Service Charters

- Observations revealed that 92.3% of the health facilities had a service charter, displayed in a prominent location where anyone walking into the hospital could read it. The charters were in the form of a "menu" of services offered, and the cost thereof, rather than being statements of commitment from the health service team, and describing the rights and responsibilities of clients.

- The content of the service charters was not standardized and varied greatly from one health facility to another; 73% of

the service charters stated the facility's mission and vision, 69% displayed the cost of services, 38% presented the clients rights and 27% presented the clients' obligation. A few (4%) of the service charters stated the health workers' obligation. The majority (92%) of the service charters were written in English with very few (4%) being written in either Kiswahili or the vernacular Kikuyu.

Availability

- **Availability of health** services
  Refers to how easily health services (either the physical space or those working in health care roles) can be reached both physically and in a timely manner.
- **Availability of health facilities and staff.**
  The health staffing levels in Nyeri County at 20 doctors and 117 nurses per 100,000 population was below the WHO-recommended average of 21.7 doctors and 228 nurses per 100,000 population, which is the required standard for optimal delivery of services[1]. The County has 113 public health facilities compared with the national standard of 106 for a population of 700,000. The population to nurse ratio is 1:654 which is above the national norm of 1:2,054. The doctor to population ratio is 1:5,000 which is higher than the national norm of 1:25,000[2]. Although health facilities are evenly distributed across the county with almost all residents living less than seven kilometers from a facility, difficult terrain and inaccessible roads increase the actual distance travelled.
- **Availability of required services, supplies and equipment.**
  A large majority (88%) of the clients that visited the health facility on the day of the survey indicated that they had received all the services that had been recommended by the health workers for their condition; 12% of the clients reported that they did not receive the recommended services. The most frequently mentioned reason for not receiving all the recommended services was unavailability of services (3.7%). Other reasons included missing drugs and supplies (2.6%); absent service provider (2.6%); missing equipment (1.8%), and referral (1.3%).

Accessibility

Accessibility to services was disaggregated into broad dimensions including physical, geographic, information, economic and organizational access.

- **Geographic access**
  Most clients indicated that they walked to the health facility (41%). Amongst the clients interviewed 92% took less than one hour to reach the facility. One participant in a focus group discussion remarked, "The health center is near".
- **Access to information**
  When asked if a health care worker gave them adequate information about their condition to meaningfully participate in their treatment, the majority of clients 92% responded in the affirmative. When asked if they felt that they could ask a health worker in the facility any question if they did not understand anything about their care and treatment, 76% agreed that they could. Most of the clients (89%) believed that they were able to spend enough time with a health worker to discuss their needs.
- **Physical access for persons with disability or injury**
  Access to the health facilities was a challenge for persons with disabilities, or

[1] Republic of Kenya, MOH (2014) Kenya Health Policy 2014-2030
[2] Kenya County Fact Sheets (2011)

patients with injuries who are unable to walk without supporting equipment. Only 34.9% of the health facilities were observed to have made reasonable accommodation like ramps to allow access for persons requiring use of wheelchairs.

- **Organizational access**
  Organizational access refers to the extent to which services are conveniently organized for prospective clients. It encompasses issues such as clinic hours and appointment systems, waiting time and provision of information about services. In all the facilities observed only half (50%) had a customer service or general inquiries desk. The majority (92.3%) of the facilities had an established system in place for receiving and serving clients that comprised "first come first" served basis and appointments. Those in need of emergency health care go through triage, stabilization, treatment and in other instances referral. The client reception system does not work optimally and there is room for improvement. Almost all the clients interviewed (93%) said that it was very easy to find the location of specific services needed in the health care facility. In 88.5% of the facilities, staff could easily be identified through their uniforms. However, only 11.5% of the health workers wear nametags.

- More than half (60%) of the respondents said that they waited for less than an hour before receiving all the services they required; 28% said they waited for between 1-2 hours before receiving the services required, while 9% took between 2-3 hours. Very few waited for less than 30 minutes. In the 'menu of services' the service charters normally promise a service delivery time that ranges from 15 to 45 minutes and do not take into account waiting time, which needs to be given more consideration.

- **Economic access**
  In general, the services offered were affordable to the clients. Most of the clients (82%) reported that they had not paid for health services. This is in line with the national health policy guidelines, which eliminated cost sharing at lower levels of health care. Amongst the clients interviewed in the facilities 46% had NHIF registration cards, which facilitate reimbursement for hospital admissions and comprehensive maternity cover in Government, Mission and Private hospitals.

Acceptability

- Acceptability relates to cultural and social factors determining the possibility for people to accept the aspects of the service (including privacy and confidentiality, the gender or social group of providers, and the beliefs associated to systems of medicine) and their judged appropriateness for the persons who seeks care.

- It was observed that 96.2% of the facilities had a private space so that consulting sessions, physical examinations and procedures could not be observed or be overheard by others. An overwhelming majority 93% of the clients, which included 46% persons with disability said that a health provider attended to them in private. More than half (52%) of the facilities had a separate room or building for HIV care and treatment.

- Overall, health services were acceptable to the clients. Almost all clients (94%) felt that they were treated with respect by all

staff and felt welcome in the facilities they visited.

- Although the general population was satisfied with the health services, some groups were identified as needing specific attention in order to attain their right to health. Groups that need specific programmes in order to achieve full access to health services include men who have sex with men, albinos, children with cleft lip or cleft palette, persons living with HIV, persons with disability, older persons, street children, and the poor and residents of remote areas.

Quality

- Quality can be described in terms of norms and standards, level of participation, and accountability for the right to health. Indicators of quality include availability of safe and portable water, sanitation, feedback mechanisms through suggestion boxes, and levels of client satisfaction.

- It was noted that all the health facilities visited (100%) had clean drinking water for their clients. Almost all the facilities had clean well-ventilated toilets for clients. However, only one facility (3.8%) provided toilet paper for use by its patients. The majority of the toilets (69.2%) did not allow easy access for persons with disabilities.

- Most of the facilities (73.1%) had in place a mechanism for obtaining feedback from clients and staff through a suggestion box.

- Almost all of the clients (93%) were satisfied with the services they received at the health facility on the day of the interview and said that they would come back in future if they ever needed any health care services. When asked what could be done to improve their experience and make it easier to use health care services there were numerous suggestions. These included increasing the variety and quantity of medication and recruiting more service providers. While the high percentage of satisfied clients could be a proxy factor forejudging quality, the number and qualifications of service providers also matter.

Conclusion

Nyeri County has made major strides towards realization of the right to health and several county specific policies are in place to guide the health service delivery. The county demonstrated leadership in enacting the Nyeri County Health Act in July 2015.This Act provides for the implementation of section 2 of Part 2 of the Fourth Schedule to the Constitution of Kenya 2010 on the functions and powers of County Governments, and to provide for a legal framework for:

a) Health for development, as per Vision 2030 and beyond, to recognize the effect of other sectors on health;

b) Facilitating realization of consumer health rights in accordance with Article 46 of the Constitution[3].

The availability of health facilities is above the country's norms and standards, and health facilities are easily accessible to residents in relation to physical, geographic, information and economic access. The services are culturally acceptable; clients feel they are treated with respect and displayed confidence in the skills of the health workers. The health facilities were of high quality in terms of the

[3] Nyeri County Health Bill 2014

level of cleanliness, water and sanitation, ease of use of social amenities and level of privacy and confidentiality. The level of client satisfaction was high and clients perceived that the quality of information they received was good. With regard to minority groups, strides have been made in addressing increasing access and involvement of persons with disabilities. The County has started training some health workers in sign language and primary rehabilitation, and has involved persons with disabilities in health facility management committees.

Recommendations

Improvements are required in relation to service delivery to minority groups, strengthening provision of medication and supplies; increased efficiency and effectiveness of administrative processes and referral systems. There is also need to strengthen referral systems and improve management of health workers. The County should continue to increase the level of investment in health systems.

The project, in consultation with stakeholders, developed a service charter for the county that is aligned to the Constitution. The service charter describes and highlights the objective, legal basis and guiding principles of the services provided. The service charter focuses on the individual's rights and responsibilities of clients when they seek health services. The charter goes further and states what actions clients can take when their rights are violated. In relation to operational frameworks, it is recommended that the county standardizes the content of the service charters at health facilities, integrates the principles and values of the constitution and facilitates health workers to appreciate and provide services using the rights based approach. This would ensure the residents of Nyeri County realize their right to health.

Chapter 1 | Introduction

1.1 Background

The Constitution of Kenya 2010 has been described as transformative. It brought fundamental changes to the political, social and economic institutions of the country. One transformative aspect of the Constitution is the introduction of a holistic bill of rights, which includes the traditional civil and political freedoms, and socio-economic, cultural as well as environmental rights. Among the socio-economic rights guaranteed is the right to the highest attainable standard of health and the right to emergency treatment, as provided for under Article 43 and Article 2(6) of the Constitution, and by virtue of certain international human rights 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.

Other provisions on the right to health include Article 46 (1) (c) on the right of consumers to protection of their health, safety, and economic interests; Article 53 (1) (c) on the right of every child to nutrition, shelter and health care; Article 54 on the rights of persons with disabilities to reasonable access to health facilities, materials and devices; and Article 56(e) on the rights of minorities and marginalized groups to reasonable access to water, health services and infrastructure. 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. 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 mandates the State to put in place policy, legislative and other measures - including the setting of standards - to ensure the progressive realization of the right to health among other rights provided in Article 43. 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.

Constitutional Values and Principles

Article 10 of the Constitution sets out the national values and principles of governance on which the state is founded. These include transparency, accountability, and participation of the people, human dignity, equity, social justice, inclusiveness, equality, human rights, non-discrimination and protection of the marginalised. It is imperative that these values and principles are respected and adhered to by all public officers, state officers, state organs and all persons in applying or interpreting the Constitution or any law and making or implementing public policy decisions. They are also quintessential to the human rights based approach.These principles are reiterated in a number of chapters of the Constitution emphasising their importance. Chapter Six is for instance dedicated to describing the principles that should guide the conduct of state officers and has been extended to all the other public officers through the Leadership and Integrity Act. Chapter Nine on the Executive

In providing for the right to health explicitly, Kenya has also, by dint of Article 2(5) of the Constitution brought internationally recognized standards to Kenya. Article 2(5) provides for the direct application of general principles of international law within the domestic legal system. In addition, Article 2(6) makes provisions for treaties or conventions ratified by Kenya to form part of the law of Kenya.

begins with an article that emphasizes the principle that executive authority is delegated from the people of Kenya and must be exercised in a manner that is compatible with providing service to the people of Kenya, and that is beneficial to their well-being. Chapter Twelve on Public Finance also reiterates the need for national resources to be managed and deployed in a manner that promotes an equitable society. Article 232 in the chapter on the Public service also emphasizes the values that must apply to the public and reiterates the principles of equality and non-discrimination, equity and inclusion.

4th Schedule – Functions of national and County Governments

Another major change brought about by the Constitution is the dispersal of power horizontally among different organs of Government and vertically between different levels ofthe national and County Governments. The creation of 47 County Governments was a departure from the previous administrative units of provinces and districts. The two levels of Government are expected to operate distinctly and inter-dependently. These changes all need to be grafted onto already existing frameworks, which have been in operation for over 50 years.

The Constitution of Kenya 2010 created two levels of Government - the National Government and the County Government. The two levels are expected to work distinctly and inter-dependently. The Fourth Schedule delineates the function of each level. The Constitution shifts service delivery in the key sectors of health, water and agriculture to the newly established County Governments. The National Government on the other hand has the mandate of formulating national policies for these sectors and the management of referral health facilities in the counties. After the General elections of March 2013, the devolved system of Government was operationalised. The transfer of functions to County Governments in line with the Transition to Devolved Government Act was done in August 2013 wherein most of the county functions on health were transferred to County Governments. The mandates of the two levels of the Government under the fourth schedule to the Constitution are clear with the National Government assigned the role of national policy development, setting of national standards, capacity building, technical support and national referral health facilities. The County Governments are assigned county health services, which include promotion of primary health care and county health facilities and pharmacies, among others, in so far as the implementation of the right to health is concerned. It is noteworthy that even where functions are assigned to one level of Government, it is expected that the two levels of Government work together. For instance, the County Government must put in place the necessary structures to enable it to deliver county health services of the highest possible standard. For this to be realised, the national Government must put in place a national policy and clear standards that will guide counties to deliver on their function, while also restructuring itself in line with its reduced responsibility over service provision.

1.2 Why rights based approaches

The rights-based approach (RBA) to health service provision and management is guided by the need to ensure respect for human rights and human dignity. RBA concerns itself with both the substance of the rights that must be fulfilled and the process of delivering these rights. It ensures the recognition of human rights in the policies, laws and operational

frameworks, guaranteeing that the 'rights holder's (the person who is supposed to receive services) needs are the key determinant for what services are provided and how they are delivered. RBA demands that the duty bearers recognize their responsibility towards the 'rights holder', and treat the rights holder with respect and dignity. The key principles of RBA are within Article 10; and they are 'equality and non-discrimination' (also 'equity' and 'inclusion''), 'transparency' and 'accountability'. The other RBA principle is the people centred approach to service delivery, an approach that is driven by the needs of the people and therefore emphasizes meaningful public participation, which is also a principle in Article 10. It is therefore accurate to say that the Constitution of Kenya 2010 has entrenched RBA as the main system for service delivery in the national and county public offices.

The Bill of Rights under Chapter Four of the Constitution and international human rights standards require 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 the diversity of the groups requiring to access health services and the responsibility to respect the human dignity of all). Incorporating both the practice and culture of institutional accountability for protecting human rights is essential to avoid shifting responsibility solely onto the service providers. Both health and development policy practitioners have a role to play in ensuring a rights based approach to health services delivery.

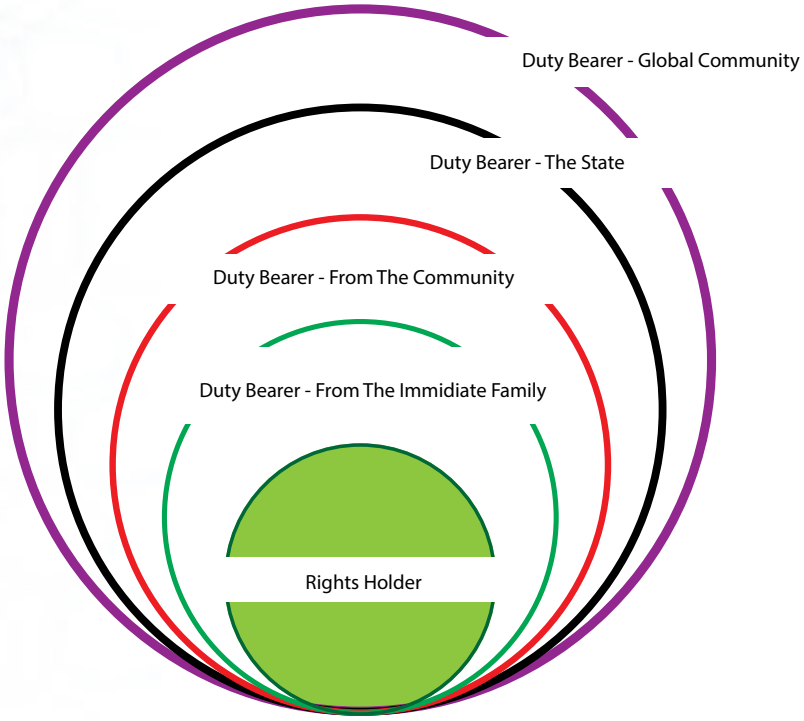
In the past, approaches to development in developing states proved to be inadequate or narrowly focussed on increasing gross domestic product (GDP) or Foreign Direct Investment (FDI) as primary outcomes, as opposed to holistic social, economic and cultural development. The UN Charter of 1945 sees human rights, and economic and social development, as closely interrelated. It commits the UN to promote development 'with a view to creating conditions of stability and well-being, which are necessary for peaceful and friendly relations among nations based on respect for the principle of equal rights and self-determination of peoples' (Article 55).

Human rights based approaches therefore demand utilization of methods whereby the process through which rights are realized is as important as the outcome. It focuses on accountability and identifying those responsible for human rights realization (duty-bearers), whose capacities to meet their responsibilities must be strengthened. As Johnson put it, actions based on a rights based approach are based on legal and moral obligations to carry out a duty that will permit a subject (rights holder) to enjoy her or his right. It also envisages a situation where everybody wears a "human rights heart," that is reflected in the manner in which decisions and actions are made.

Rights' holders must navigate different spaces - from the household, to the immediate and extended family, and the community at large - before presenting at the healthcare facility (see Figure 1 below). The rights holder may face impediments to realizing their right to health for a variety of reasons. The technical nature and professionalization of health care services does not lend itself easily to access by the general public. The health care providers may also fail to provide the requisite standard of services on account of lack of organizational capacity and lack of knowledge on and awareness of rights based approaches.

Office of the High Commission for Human Rights (2013): Realizing the Right to Development Essays in Commemoration of 25 Years of the United Nations Declaration on the Right to Development, United Nations Publication Pg 53-54 I 'The Charter of the United Nations', signed on 26 June 1945
Urban Johnson: 2003 Human Rights Approach to Development Programming pg 7 I Note 2 as above Pg. 20

Figure 1:Realizing the right to health – rights holders and duty bearers



In using a rights based approach, one also needs to understand the right to health in a holistic manner to be to be able to apply the principle. The right to health must be seen as a right and a requisite means of recognizing other human rights . In this context the right to health ought to be understood as generating conditions in which people may be healthy both physically and mentally vis-à-vis the highest attainable health standards. The right to health takes into consideration the following factors: access to medical services; appropriate sanitation; nutritious food; decent housing; healthy working conditions; and a clean environment. Broad strategies for delivery of health functions include preventive, promotive, curative, rehabilitative and palliative services.

State as principle duty bearer

The rights language used in relation to health, water and sanitation implies that there is a rights holder and a duty bearer. The state has been seen as the principal duty bearer but it has become clear that the capacity of the state to deliver may need complementing from non-state actors given the high demand and extensive needs for the services. Where the County Government is responsible for

Human rights are interdependent, indivisible and interrelated in that; if you violate the rights to health it impairs the enjoyment of other human rights.
http://www.ohchr.org/documents/publications/factsheet31.pdf (accessed 14 December 2014)
http://www.nesri.org/programs/what-is-the-human-right-to-health-and-health-care (accessed 14 December 2014).

service delivery, there is need to define the way in which the national Government works with the County Governments to perform its treaty obligations in international law. This relates to both actual service delivery and to resource allocation and sourcing, especially where development partners and international financial institutions are involved. It also requires a facilitative policy and legislative framework.

1.3 Elements of the right to health

International human rights instruments take a rights based approach to the right to health based on four elements: availability, accessibility, acceptability and quality (3AQ).

- Availability entails the outlook of the right to health from an infrastructural basis i.e. numbers of doctors, hospitals, medicine etc. and their availability in a geographical area.

- Accessibility is centred on the notion that healthcare should be affordable and comprehensive for everyone on an equitable basis. It also regards physical accessibility of health facilities based on the geographical location. Having access means that health care services are not restricted by geographic, economic, social, cultural, organizational, or linguistic barriers, and it therefore influences utilization of services.

1. 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;

2. Economic access refers to the affordability of products and services for clients. The concept of the hidden costs of services come into play;

3. Social or cultural access relates to service acceptability within the context of the client's cultural values, beliefs, and attitudes. Religious beliefs also play a role here, e.g. groups that do not allow blood transfusions;

4. Organizational access refers to the extent to which services are conveniently organized for prospective clients and encompasses issues such as clinic hours and appointment systems, waiting time, inappropriate eligibility criteria (e.g. no family planning services for adolescents), arrangement of rooms, labeling, physical layout and access (e.g. ramps for disabled persons), and the mode of service delivery;

5. Linguistic access means that the services are available in the local language or a dialect in which the client is fluent. Apart from the obvious differences in the spoken language, linguistic access comes into play significantly where the client is deaf, and therefore largely relies on sign language to communicate. If the health facility does not have health workers who are trained to communicate in sign language, a number of clients can be denied access to crucial services.

Acceptability on the other hand, is based on the principle of respect of individuals in medical ethics and the protection of medical confidentiality. The dignity of an individual ought to be respected while being responsive to their medical needs based on their social status.

- Quality can be described in terms norms and standards, level of participation, and accountability. In addition to the participation of both individuals and the community, they should have an active role in making decisions related to health.

Art 25 UDHR, art 24 CRC, art 5 CERD, art 12 & 14 CEDAW, art 25 CRD and art 12 ICESCR. See also General Comment. No. 14 of the Committee of Economic, Social and Cultural Rights that brings on board the issue of quality other than accessibility, acceptability and availability.
Brown, L. D., Franco, L. M., Rafeh, N., & Hatzell, T. (2000). Quality Assurance of health care in developing countries. Bethesda, MA: Published for the U.S. Agency for International Development (USAID) by the Quality Assurance Project pp 8 - 12

Accountability lays emphasis on institutions being held accountable for protecting the right to health through enforceable standards, regulations and independent monitoring of compliance.

The table below summaries the elements of the right to health and proxy indicates that can be used for assessments.

Table 1: Elements of rights based approach and proxy indicators

	Element	Associated Principles	Proxy indicators
1	Availability	Functioning public health-care facilities, goods, services and programmes Availability and sufficient quantity Equity, social justice, inclusiveness, equality	Number of health facilities per population Ratio of doctors and nurses to population Level of equity (distribution per sub county) Availability and adequacy of equipment Adequacy of services Availability of medication and supplies e.g. condoms
2	Accessibility	• Physical and economic access • Access to information • Non-discrimination • Protection of marginalized • Respect for human dignity • Inclusiveness	• Extent of geographic, physical, information, economic access, • Level of organizational access: signage opening hours, waiting time, uniform, name tags, • Extent of inclusiveness of minority groups
3	Acceptability	• Respectful of medical ethics • Culturally appropriate • Respectful of individuality, human dignity • Promoting informed choice • Right to choose • Respect for religion, beliefs and opinions • Freedom of expression	• Level of privacy, confidentiality, freedom of expression, choice, • Extent of social cultural acceptability
4	Quality	• Medically appropriate and good quality • Skilled medical personnel • Appropriate medication and equipment • Safe and potable water • Adequate sanitation • Clean and healthy environment • Accountability	• Level of cleanliness • Availability of water and sanitation • Perceptions on quality of services, • Level of participation, involvement, feedback • Status of suggestion boxes • Adequacy of service charter

1.4 Statement of the problem

Whereas the Constitution has entrenched human rights' principles such as equality and non-discrimination, equity, transparency and accountability, social justice, the rule of law, public participation and inclusiveness among others under Article 10, the application of these principles in public service delivery in all sectors is yet to be appreciated and applied. It should be noted that we are only in the third year of transition from the centralised governance system to the devolved system of Government, yet the challenges facing implementation of the Constitution are many at both levels of Government. One big challenge to implementing Article 10 is the difficulty in changing the work culture from the pre-2010 constitutional era when values like the rule of law, transparency, accountability, equality and non-discrimination, and public participation were not required as a matter of constitutional obligation. Most state organs at the national and County Governments are yet to internalize their responsibility under Article 10 and have therefore not reviewed their institutional frameworks to ensure compliance.

In line with its mandate to facilitate the implementation of the Constitution and under its strategic result on effective institutional frameworks and procedures for the implementation of the Constitution, CIC in partnership with the counties of Bungoma, Nyeri and Kitui; and with the support of DANIDA, initiated a project on integrating Constitutional values and principles, particularly those in Article 10 (which include the rights based approach to service delivery) into the operational frameworks and work culture of health care facilities in Bungoma, Nyeri and Kitui Counties. Following negative media reports on alleged mistreatment and violation of the rights of some patients in various health facilities around the country, CIC made a decision to work with Bungoma, Nyeri and Kitui counties on this project. Bungoma and Nyeri were selected for being among the counties where mistreatment of patients had been reported while Kitui was picked as the third county to include a third region. The three County Government health department teams and the offices of the governors were visited and consultations held to determine the counties' willingness to participate in the project. All the three counties were willing to participate.

The project aimed at reviewing the operational frameworks and culture in the county health care facilities against the constitutional values and principles with a view to making recommendations that may facilitate the County Governments to come up with practical interventions that will see the integration of the rights based approaches and other constitutional values and principles in health service delivery in Nyeri County. The key deliverables of this project were improved health service delivery charters for Nyeri County that comply with the Constitution of Kenya 2010, alongside this report and its recommendations, whose aim is to help transform the County's health service delivery culture, going forward.

1.5 Objectives of the project

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:

1. Audit the service charters of the County's health facilities against the Constitution, review and align them with the constitution;

2. Audit the County's health facility operational frameworks including the policies, regulations and guidelines, management tools and the service delivery cultures and make recommendations on how they can be improved, integrating the values of the constitution and the rights based approach to service delivery into them.

3. Develop the capacities of the County's health sector teams on the right to health in the constitution, their implementation responsibility under Article 10, including the rights based approach to service delivery and health as a devolved function.

4. 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.

1.6 Expected results of the project

1. Short-term- Revised county health facility charters that are rights based and compliant with the Constitution of Kenya 2010;

2. A comprehensive report on the status of service delivery in Nyeri county health facilities and recommendations on how it can be improved.

3. Long-term county health care facilities that espouse a work culture that is guided by the values and principles of the constitution where:

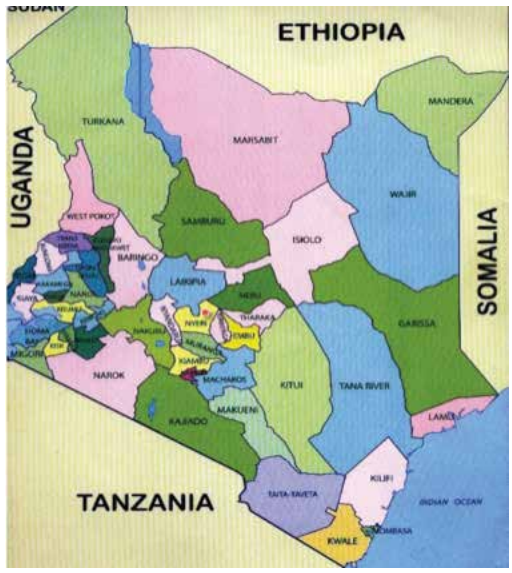
- The rights of service recipients are respected and protected; and,

- The service providers are operating in an environment that enhances their outputs while respecting their rights.

1.7 Profile of Nyeri County

Nyeri is one of the 47 counties in Kenya and borders Laikipia County to the north, Kirinyaga County to the east, Murang'a County to the south, Nyandarua County to the west and Meru County to the north east. Nyeri County covers an area of 2,475.4 square kilometers and is divided into eight Sub-Counties namely Nyeri Central, Nyeri South, Tetu, Mukurweini, Mathira East, Mathira West, Kieni East and Kieni West. The main physical features include Mount Kenya, which is 5,199m above sea level to the East and the Aberdare ranges, 3,999m above sea level to the West.

Figure 2: Map of Counties in Kenya



Organisation of health facilities

Nyeri County has 113 public hospitals, which offer a wide range of preventive, promotive, curative and rehabilitative health services that are organized to provide access to 3 tiers of service delivery. They include 5 public hospitals, 3 hospitals run by faith based organizations (FBO) and 3 private hospitals in tier 3 that act as the county referral facilities. Among these facilities, only Nyeri County Referral Hospital (PGH) has the infrastructure to handle most of the medical complications referred from Nyeri County and other counties. In tier 2, there are 108 public health centres and dispensaries and 32 community units provide care at tier 1. There are 17 health centres and dispensaries run by FBOs, and 228 private clinics providing a wide range of health services to the Nyeri County population. On average, the population can access a health facility within a radius of at least 7 km.

In general, the availability of public health facilities, doctors and nurses in Nyeri County is above the national norms and standards but below WHO standards. The health staffing levels in Nyeri County is at 20 doctors and 117 nurses per 100,000 population, below the WHO-recommended average of 21.7 doctors and 228 nurses per 100,000 population, which is the required standard for optimal delivery of services . The County has 113 public health facilities compared to the national standard of 106 for a population of 700,000. The population to nurse ratio is 1:654 which is above the national norm of 1: 2,054. The doctor to population ratio is 1:5,000 which is higher than the national norm of 1: 25,000 .

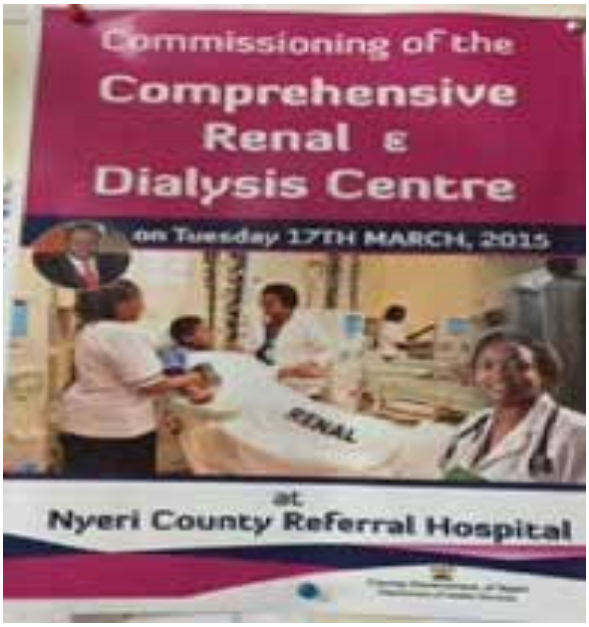


Figure 3: Renal and Dialysis Centre

Republic of Kenya, MOH (2014) Kenya Health Policy 2014-2030 I Kenya County Fact Sheets (2011)
Republic of Kenya (2010) National Population and Housing Census Report
County Government of Nyeri(2014) Nyeri County Health Sector Strategic & Investment Plan 2013 - 2018 Department of Health Services
County Government of Nyeri(2014) Nyeri County Health Sector Strategic & Investment Plan 2013 - 2018 Department of Health Services Ibid 21

Demographic and health indicators

Nyeri County has a population of 707,003 and 201,703 households with a growth rate of 0.48%. The county is experiencing an epidemiological transition from communicable infectious diseases towards non-communicable diseases. This presents a 'double burden' of diseases that entails a lingering communicable disease burden with an increased burden of non-communicable diseases. The County's referral system is weak due to inadequate and old ambulances that are expensive to maintain.

Nyeri County Hospital has the infrastructure and capacity for referral of large numbers of complications from Nyeri County and the surrounding five counties. Numerous clients from Laikipia, Nyandarua, Kirinyaga, Murang'a and Meru therefore utilize the health services, such as the renal and dialysis center, offered in the hospital, which provides both a challenge from a resource perspective and an opportunity for development of formal intra-county partnerships.

Health workforce

Despite having in employment a high number of doctors and nurses that is above the national norms and standards, the numbers are below WHO norms and the distribution and management of the health workforce is a major challenge. Nyeri county is experiencing a severe shortage of the health workforce across all cadres, worsened by the coming up of new facilities funded through the Constituency Development Fund (CDF) and the expansion of health services in the existing facilities. The County is experiencing a shortfall of 4,481 health workforce in the health facilities and 1,584 shortfall of community health workers. The workforce is also demotivated, especially in Nyeri County Hospital due to the large numbers of medical referrals.

The County, working with implementing partners through USAID (Centre for Health Solutions and Capacity Kenya Project) and VIDHA, has supported employment of health workers, on contract terms for a total of KES 3,024,135 per month. The County continuously addresses the issue of staff shortages by:

- Absorbing the staff working under partner funded programs;
- Absorbing and mainstreaming all Economic Stimulus Program (ESP) staff into the County health workforce;
- Recruiting on service-need basis, subject to availability of finances;
- Replacing the staff leaving the service through retirement and natural attrition without delay;
- Continuously motivating, capacity building and promoting staff on merit for retention of skilled and experienced workforce;
- Completing the process of restructuring of the health workforce through staff audits and payroll rationalization.

Chapter 2 | Project Methodology

The project utilized a participatory and capacity building approach: 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. They used 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 in 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 integrating them in the tools determined for the delivery of the products for the project;
- Ensuring inclusion of vulnerable and marginalized populations, including women, children and older persons;
- Preparing and presenting progress reports on various activities; and
- Drafting the final charters for the county health facilities, the final project report and contributing to the overall project report.

2.1 Scope

The assessment covered a sample of 26 health facilities in five levels of health care in all the eight sub-counties of Nyeri County. Of the 26 health facilities, one was a referral hospital, one district hospital, two sub district hospitals, 11 health centres and 11 dispensaries. The decision on the number of health facilities to visit was reached through purposive sampling to cover a wide range of the facilities through which the county residents access health services. Sampling was done to ensure equitable distribution per category of facility in each sub-county; at least one health centre and dispensary was sampled in each sub county. The survey covered all district, sub-district and referral hospitals in the county.

Table 2: Health facilities visited by Sub County

	Sub county	Health Facilities		Facility	Dispensary	Health Centre	Sub District	District	Regional Referral
		No	%						
1	Kieni East	3	11.5%	Burgureti	1				
				Naromoru		1			
				Ndathi	1				
2	Kieni West	3	11.5%	Amboni	1				
				Endarasha		1			
				Mweiga		1			
3	Mathira East and West	5	19.2%	Kangocho	1				
				Karatina				1	
				Kiambara		1			
				Ngorano		1			
				Ngurumo	1				
4	Mukurweini	4	15.4%	Ichamora	1				
				Karaba		1			
				Mukurweini			1		
				Tambaya	1				
5	Nyeri Township	4	15.4%	Kiganjo		1			
				Marua	1				
				Nyeri PGH					1
				Gatitu		1			
6	Othaya	4	15.4%	Kagicha	1				
				Kariko	1				
				Othaya			1		
				Witima		1			
7	Tetu	3	11.5%	Ichagaciru	1				
				Ihururu		1			
				Wamagana		1			
	Total	**26**	**100%**		**11**	**11**	**2**	**1**	**1**

2.2 Data collection methods and tools

Several methods and tools were used to collect data. Android phones were programmed with the tools to enable research assistants to collect electronic data from the client exit interviews and health facility observation guide. Information was captured using a variety of formats and devices including paper, video tape recordings and digital voice and data recorders.

- Client exit questionnaire - This tool was used to interview 1 - 10 clients in each facility, who had already received outpatient services and were exiting. The research assistants introduced themselves to the clients and obtained consent before proceeding with the interview. The questionnaire established (i) the background of the client in terms of gender, where the client lives, if the client had a disability or not, satisfaction with services received, referrals and suggestions on areas for improvement.
- Structured questionnaires were used to interview all cadres of health care workers within each facility. Between 1 – 10 health workers were interviewed in each facility.
- Health facility observation guide - This tool was used to collect data both at the inpatient and the outpatient departments and involved the use of the sense of sight, smell and inquiry about location of equipment's and services in the health facility. This also involved photography for documentation. Data was collected on a printed tool and transferred to the android phone at each site.

2.3 Profile of respondents

A total of 198 clients accessing health services and 112 health workers were interviewed. Key informants at the facility level comprised 26 officers in charge of the health facilities and involved nursing officers (84.6%) clinical officers (11.5%) and medical superintendents (3.8%). Six focus group discussions were held with different groups: persons with disabilities, women, people living with HIV, workers in the informal sector (jua kali), sex workers and community health volunteers.

Table 3: Number and % of respondents by facility type

No	Type of facility	Respondents					
		Health workers		Clients		Facility In Charge	
		N	%	N	%	N	%
1	Dispensaries	24	21	59	30%	12	48%
2	Health centre	44	39%	92	46%	10	38%
3	Sub-district Hospital	10	9%	21	11%	2	8%
4	District Hospital	6	5%	11	6%	1	4%
5	Provincial General Hospital	28	25%	13	7%	1	4%
	Total	**112**	**100**	**196**	**100**	**26**	**100**

Figure 4: Collecting data using phones

Figure 5: FGD with women

The majority of the health workers and clients were female: of the 196 clients interviewed in Nyeri County, 66% were female and 34% male. Of the 112 wealth workers interviewed 70% were female and 30% male. The highest number of clients and health workers interviewed were between ages of 31-50.

The majority of the clients interviewed were long-term residents in the county. Most of clients (63%) had lived in the County for more than 8 years, 17% had lived in the County for between 4-8 years, 15% had lived there between 0-3 years while only 6% said they were visitors in the County. A large majority of the clients interviewed (85%) were on a repeat visit and only 15% were first time visitors. Clients visiting the facilities said they did so because it was the nearest and cheapest health facility which offered a wide range of services.

Amongst the respondents interviewed, 74% were receiving medical attention while 26% had accompanied a client to the health facility. Out of the 196 clients interviewed 10 (5%) had disability. Most of the clients with disabilities had physical disabilities as shown in the table below.

Table 4: Clients interviewed by disability type

Disability type	Clients	
	N	%
Physical	6	60
Hearing	1	10
Visual	1	10
Visual and hearing	1	10
Visual, hearing, physical,	1	10
Total	**10**	**100**

Half (50%) of the staff interviewed had worked in the health service for more than 5 years: (31%) had worked in the health service for between 3-5 years; 12% had worked for between 1-2 years and only 7% reported they had worked in the health service for less than 1 year.

During the study, a total of 26 observations were conducted in all the health facilities visited in Nyeri County, which included dispensaries (46.2%), health centers (34.6%), sub county health facilities (15.3%) and the county referral hospital (3.8%). The number of clients served in the health facilities ranged from 350 to 20,000 clients per month.

2.4 Data quality assurance

Several measures were undertaken to ensure quality data was collected. This included a participatory development and review of methods and tools with the national and county oversight teams, training of research assistants, pre-testing of the tools, using android mobile cell phones to collect data, obtaining necessary approvals and taking into consideration ethical issues. In an effort to ensure that quality data was collected, skilled and experienced enumerators working in Nyeri County were recruited. All enumerators were trained in data collection e.g. interviewing techniques and recording of data. To ensure high quality, consultants cross-checked the data collected on a daily basis for validity, consistency, accuracy and completeness.

Training of Research Assistants - The research assistants participated in a three-day training in Nairobi and a one day training in Nyeri, prior to data collection. The objective of this training was to support the participants to:

Understand the objectives, methods and expected outcomes of the project;

Use the tools to collect data for development of a county profile and county and health facility charters;

Provide input and explain the purpose, audience and approach for each data collection tool;

Provide input into the planning of logistics for data collection, county forums on the analysis report, validation, and launch of County Health Service Charters.

The research assistants had ample opportunities to practice using the android cell phones to collect data and grasp the meaning and purpose of each question. Role plays provided an opportunity for the research assistants to fine tune their interview techniques and also ensured that participants were well prepared and had experienced different scenarios that they might encounter in the field.

Pre-Testing of tools- The objective of this activity was to practice using the tools and make any necessary changes required to fine-tune the tools ready for data collection.

Ethical Considerations and Approvals - All activities were conducted using the highest ethical standards. Approvals were obtained from the relevant authorities including CIC and the County Governments who provided letters authorizing the activities. Informed consent was obtained prior to collecting data from all participants . Participation was completely voluntary and participants were notified of the freedom to withdraw at any time during interviews. The consultant teams and enumerators adhered to the highest level of confidentiality while they handled the data.

2.5 Data analysis

After data collection, the quantitative data was downloaded from the mobile phones, processed and analyzed using Statistical Package for Social Sciences (SPSS) to obtain frequency distributions and cross tabulations. Qualitative data was thematically analyzed. Transcription of the recorded data from key informant interviews and focus group discussions was done and summarized to ensure that all the relevant aspects were captured. Both quantitative and qualitative data was analyzed and triangulated to obtain a comprehensive analysis and interpretation of the current situation, desired outcomes and possible interventions, and compiled into the Nyeri County Report. The findings were discussed at several national and county level forums.

The analysis identified key operational concerns that exist and made recommendations for the improvement of the service delivery culture in these facilities and the work environment. The results of the analysis guided the development of a proposed County Health Service Charter that provides an operational framework for a work culture that is rights based, people centered and compliant with the Constitution.

Limitations

The main limitation of the study was the short duration, which did not enable the long-term objectives to be achieved. Although the short-term result of developing a service charter was achieved, the long-term result of confirming that health facilities espoused a work culture guided by the values and principles of the Constitution could not be assessed. It is recommended that CIC develop mechanisms to facilitate and monitor the integration and implementation of the rights based approach to health within the counties for the long term. Another limitation was the possibility of inter-observer bias in the health facility observation tool. It was realized that inter- and intra-observer error could have occurred when research assistants completed sections of the tool used to observe the health facility. In future, the tools should be better standardized to reduce errors.

County Health Service Charter that provides an operational framework for a work culture that is rights based

Chapter 3 | Legislative and Policy Frameworks

This section presents the international, regional and national legislative frameworks that address the right to health and health services in Kenya. It also specifically examines the policies that have been adopted in Nyeri County.

3.1 International frameworks

At international level the global community is concerned about the welfare as well as the health of individuals. The concern is reflected in the many legislative and policy frameworks adopted to address the issue. The right to health is guaranteed under international instruments and declarations, ranging from the Universal Declaration of Human Rights (UDHR), International Convention on Economic Social and Cultural Rights (ICESCR), Convention on the Elimination of All forms of Discrimination Against Women (CEDAW) and the Convention on the Rights of the Child (CRC), among others. International human rights norms demand that priority is given to health for vulnerable groups such as the very poor within all these groups. The human right to health illustrates the indivisibility and interrelatedness of human rights. Superseding the divides between civil, political, social and economic rights, the right to health is closely related to the rights to water, sanitation, food, livelihood and equality, and is embedded in the ICESCR, the CEDAW and the CRC.

(i) The Universal Declaration of Human Rights (UDHR)

UDHR recognizes the inherent dignity, equality and inalienability of rights of all members of the human family as the foundation of freedom, justice and peace in the world, and declares the universality of rights at its preamble. Article 25 (1) makes general reference to everyone in terms of the right to a standard of living adequate for health and well-being. It provides for several conditions necessary for the fulfilment of this right, which includes medical care and necessary social services, among others. Special reference to women is found at Article 25(2), which provides that motherhood and childhood are entitled to special care and assistance.

(ii) The International Convention on Economic Social and Cultural Rights (ICESCR)

Article 12 guarantees everyone the enjoyment of the highest attainable standard of physical and mental health. It mandates state parties to take the steps necessary for the achievement of the realization of the right to health. General Comment No. 14 of ICESCR was adopted by the Committee of ESCR to address the right to health and related issues as envisaged under Article 12 of ICESCR. At the outset, it recognizes health as a fundamental human right indispensable for the exercise of other human rights, and the fact that every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. Paragraph 5 acknowledges that despite the right being guaranteed, its realization is still a distant goal for many globally.

The right to health is given a wide interpretation under Paragraph 11, which includes timely and appropriate health care as well as the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. It also entails the participation of the population

Article 12(1) of ICESCR-Such measures include reduction of the stillbirth-rate and of infant mortality, prevention, treatment and control of epidemic, endemic, occupational and other diseases; creation of enabling conditions for access to all the medical service and medical attention in the event of sickness among others. CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000. UN Document E/C.12/2000/4)

in all health-related decision-making at the community, national and international levels. This is particularly important for integrating rights based approaches in the health delivery system as it provides sound interpretation of the health to right in a holistic manner. Paragraph 12 states the interrelated and essential elements of health are availability, accessibility, acceptability and quality of service. These are crucial for ensuring the realization of the highest attainable standard of health for all as contemplated in the various international instruments.

(iii) The Convention on Elimination of All forms of Discrimination Against Women (CEDAW)

This convention specifically addresses issues concerning women, health included. It is borne of the notion that even though women and men suffer inequalities and inequities in society, women are disproportionately affected. Article 12 routes for elimination of discrimination against women in health care and guarantees equal access for women and men to health-care services including family planning. Article 14 requires state parties to ensure rural women participate in and benefit from rural development, have access to adequate health-care facilities and services in family planning among others. Further mandate imposed is the provision of health care services related to pregnancy, childbirth and the post-natal care. The preamble to the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) links law and development stating that 'the full and complete development of a country, the welfare of the world and the course of peace require maximum participation of women on equal terms with men in all fields.

(iv) The Convention on the Rights of the Child (CRC)

This convention is concerned with child related issues. It takes cognizance of challenges that children go through and the necessary measures that state parties must undertake for the realization of the rights guaranteed including rights to health. As is often the case, children or adolescents face numerous barriers when the access healthcare services. Article 24 affirms the states parties' recognition of the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. It creates an obligation to the state parties to ensure children are not deprived of their right to access health-care services.

(i) The International Conference on Population and Development (ICPD)

ICPD put human rights at the centre of development and takes cognizance of human concerns too central to development. It calls for a comprehensive approach to sexual and reproductive health and reproductive rights, recognizing that sexual and reproductive health services and programmes must be guided by the needs of, and must protect the human rights of, individuals.

Paragraph 8.3 spells out the objectives of the Plan of Action around health that are two- fold: One is to increase the accessibility, availability, acceptability and affordability of health-care services and facilities to all people in accordance with national commitments to provide access to basic health care for all. The second objective is to increase the healthy life-span and improve the quality of life of all people, and to reduce disparities in life expectancy between and within countries. These objectives fit into the context of rights based approaches.

'The UN Convention on the Elimination of All Forms of Discrimination against Women', adopted 18 December 1979, entered into force 3 September 1981 | Principle 1 and 3 of ICPD | ICPD 1994 Programme of Action of the UN ICPD 1994 Para 8.3

3.2 Regional frameworks

This sections looks at the regional instruments and policy framework dealing with health within the African continent. They include (i) the Africa Charter on Human and People's Rights (ACHPR), (ii) the African Charter on the Rights and Welfare of the Child (iii) the Protocol to African Charter on Human and Peoples Rights on Rights of Women and (iv) the Africa Health Strategy.

(i) The Africa Charter on Human and People's Rights (ACHPR)

The right to health in the African Charter is enshrined in article 16. This article resonates what is in the major international human rights on health. It recognizes that everyone has a right to enjoy the best attainable state of physical and mental health. It also obligates state parties to take the necessary measures to protect the health of their people, and to ensure that they receive medical attention when they are sick. Article 18(1) recognizes the family as the natural unit and foundation of society and obligates the state to protect and take care of family's physical health.

(ii) The African Charter on the Rights and Welfare of the Child

This charter makes provision for the protection of child rights. Article 14 provides that every child has a right to enjoy the best attainable state of physical, mental and spiritual health. For the realization of these rights, the charter obligates state parties to reduce infant mortality, provide necessary medical assistance and health care to all children with emphasis on the development of primary health care, develop preventive health care and family life education and provision of service as well as meaningful participation of stakeholders in the planning and management of a basic service programme for children. Governments are also required to mobilize resources for development of primary health care for children.

(iii) Protocol to the African Charter on Human and People's Rights on the Rights of Women (Maputo Protocol)

This charter, also known as the Maputo Protocol, aims to protect the rights of women in Africa and is equivalent to CEDAW . Article 14 advocates for the protection of women's health, which encompasses sexual and reproductive health. Notable of the rights guaranteed include control of fertility, number and spacing of children, contraception, protection against sexually transmitted diseases and family planning education. Governments are mandated to provide adequate, affordable and accessible health services, including information, education and communication programmes to women. States are also required to protect reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus. This is seen as a provision that allows or promotes safe abortion by the state in the special circumstances mentioned, which expand the conditions under which someone may seek such services.

(iv) Africa Health Strategy: 2007 – 2015 Index

This regional policy framework provides a strategic direction to Africa's efforts in creating better health for all, and complements existing national and sub-regional strategic documents.

Africa Charter on Human and People's Rights adopted the Charter on 7June, 1981 and it entered into force on 21st October 1986
African Charter on the Rights and Welfare of the Child adopted the Charter on 7June, 1990 and it entered into force on 29th November 1999. Protocol to the African Charter on Human and People's Rights on the Rights of Women of Africa adopted on 13th September 2000, and entered into force on 25November 2005

The strategy proposes strengthening of health systems with the goal of reducing disease burden through improved resources, systems, policies and management. The proposal is aimed at ensuring equity through a system that reaches the poor and those most in need of health care. It acknowledges the huge burden Africa's people face in preventable and treatable health problems, which adversely affect development in the continent. It lays emphasis on functional health system as cornerstone for a country's sound and basic health care service delivery to the citizens.

The strategy also provides for the key ingredients that make up a functional health system to include human resources for health, transport, ICT, facilities, medicines and supplies. It affirms health as a human right entitlement that is enforceable, and therefore Governments have a responsibility for guaranteeing health care for all their citizens in an equitable manner and with clean and efficient governance and prudent use of resources. Other interventions proposed include strategies of empowering and involving communities to ensure ownership and sustainability of programmes. It recommends community participation as an all-inclusive process, not limited to cost sharing only, but also other aspects like reporting problems in the health systems. It expects that community participation must be meaningful. The strategy calls upon African countries to promote all aspects of human resources for health development and retention, addressing policies, strategic plans, information, training, recruitment, deployment and retention, administration, working and living conditions and the health of staff.

3.3 National frameworks

At national level, there are also legislative and policy frameworks that address the health needs of the citizen. The legislations include the Constitution, Vision 2030 and the Public Health Act.

(i) The Constitution

Article 43 makes reference to health as a constitutional, economic, social and cultural right. In particular Article 43(a) guarantees everyone the right to the highest attainable standard of health, including the right health care services as well as reproductive health care. Article 20 provides that the Bill of Rights applies to all laws, and binds all state organs and all persons. More specifically Article 20(5) (a) provides that in applying any right under Article 43, if the state claims that it does not have the resources to implement the right, a court or tribunal or other authority shall be guided by the following principles: it is the responsibility of the state to show that the resources are not available; (b) in allocating resources, the state shall give priority to ensuring the widest possible enjoyment of the right while having regard to prevailing circumstances, including the vulnerability of particular groups or individuals.

Article 21 obligates the Government and its organs to observe, respect, protect, promote and fulfill the rights and fundamental freedoms. Further the Government is under a duty to take legislative, policy and other measures including setting standards to achieve the realization of the economic, social and cultural rights, which comprise right to health. Article 26 provides for the right to life and at sub-section (4) permits abortion for emergency treatment or when the life of the mother is in danger, or if permitted by any other written law. This promotes safe

Africa Health Strategy: 2007 – 2015- CAMH/MIN/5(III)
Africa Health Strategy: 2007 – 2015 Para 30-32
Africa Health Strategy: 2007 – 2015 Para 75

motherhood. Reference to 'permitted by the law' here could be given a wide and liberal interpretation to mean international law as stipulated under Article 2(6). Other relevant provisions include Article 32 which provides for freedom of conscience, religion, belief and opinion; Article 46 on the right of consumers to protection of their health, safety, and economic interests.

Articles 53-57 on rights of special groups including the right of the child to nutrition, shelter and health care (Article 53(c)), right to reasonable access to health facilities, materials and devices for persons with disability (Article 54), youth right to relevant education and protection from harmful cultural practices (Article 55) and right to reasonable access to water, health services and infrastructure for minority and marginalized groups (Article 56(e)) among others. These provisions in the constitution reflect the spirit and letter of the law as contemplated in the major international instruments that guarantee the right to health and are an attempt by the Government to comply with its international obligations as far as the right to health is concerned.

(ii) Vision 2030

The long term development blueprint for Kenya has health as one of the components of delivering the Vision's Social Pillar. This blue print was developed before the promulgation of the constitution and does not therefore fully articulate the tenets of health as a human right and the state obligation to develop a service culture that integrates all the values and principles in the constitution.

(iii) Public Health Act Cap 242

This is the legislation that currently provides for securing and maintaining health within the Republic of Kenya. It creates structures and institutions for administration and management of health services, including a Central Health Management Board established under section 3 of the Act, and the District Health Management Boards created under Section 7B. The District Boards had an oversight role of the running of the health functions and services in the respective districts. These structures no longer exist and are likely to be faced out in the new health law that is being developed to reflect the new system of governance. County Governments are in the process of establishing health facility management committees to carry out similar functions as was expected of the boards under the Public Health Act. The health sector is guided by very many national laws and policies that were in place before 2010; these need to be reviewed to align to the Constitution.

(iv) Nyeri County legislation and policies

The document review revealed that Nyeri County has demonstrated leadership in the development of seven County specific laws, policies and frameworks, which include (i) Nyeri County Health Services Act (ii) Nyeri County Health Policy (iii) Nyeri County Health Sector Strategic and Investment Plan 2013 – 2018 (iv) County Fiscal Strategy Paper 2014 to guide economic transformation in the county as well as (v) Programme Based Budget (vi) Itemized budget 2015/2016 and (vii) County Health Services, Monitoring and Evaluation Plan to guide performance management.

County Fiscal Strategy Paper 2014, Economic Transformation for a Shared Prosperity in Nyeri County, February
Programme Based Budget 2015/2016, April
Itemized Budget 2015/2016, April

(i) Nyeri County Health Services Act, 2015

In August 2015 the Nyeri County Assembly enacted the Nyeri County Health Services Bill into law to provide for the implementation of section 2 Part 2 of the Fourth Schedule on county health services. The purpose of this law is to provide a legal framework for: health for development under Vision 2030, recognizing the effect of other sectors on health; and to facilitate the realization of consumer rights in accordance with Article 46 of the Constitution. Among the principles of heath service delivery under section 4 of the Act are that health services shall be available, accessible, acceptable, affordable and of good quality and standard; and health rights of individuals shall be upheld, observed, promoted and protected.

The law underscores the functions of the department responsible for county health to include the coordination of the provision of preventive, promotive, curative, rehabilitative and palliative health services (Section 5 (a)); liaise with regulatory bodies in the enforcement of norms, standards and best health practices (Section 5 (c)); ensure compliance with norms and standards for health facilities and health services (Section 5 (f)); ensure the implementation of the rights to health specified in the bill of rights, and more particularly the progressive realization of the right to the highest attainable standard of health, including reproductive health care and the right to emergency treatment (Section 5 (g)); develop and implement measures to promote equitable access to health services to the entire population, with special emphasis on eliminating the disparity in the realization of the objects of the bill for minority, special groups, marginalized and disadvantaged populations (Section 5 (h)); facilitate capacity building and professional development for health service personnel (Section 5 (j)); ensure and coordinate the participation of communities in the governance of health services so as to promote a participatory approach in health care governance (Section 5 (p)); promote realization of health rights (Section 5 (q)); procurement and management of medical supplies and commodities (Section 5 (r)); develop and manage the county health referral system, including ambulance services (Section 5 (s)); provide for the development, strengthening and expansion of a county health information management system (Section 5 (y)), among others. These functions are facilitative of better service delivery and form the bedrock of the service charter.

The Act pays special attention to the human resources and institutional and management structures required for implementation. It requires each county health facility to adapt a health service delivery system guided by the County Health Policy Framework. The standard setting and conformance under the Act extends to private health facilities. Significantly, the Act provides for the rights of health care workers to a safe, clean working environment that minimizes the risk of disease transmission, injury, damage or attack while performing their duties. The Act requires that each health facility maintain the highest quality level of health services according to nationally and internationally accepted norms and standards.

(ii) Nyeri County Health Policy 2015-2030

This policy proposes a comprehensive and innovative approach to harness and synergise health services delivery at all linked health service levels and engaging duty bearers, rights holders, state and non-state. The Policy takes into account the objectives of devolution such as:

- Promotion of inclusiveness and accountability in delivery of healthcare;
- Facilitation of powers of self-governance to the people and enhancing their participation in making decisions on matters of health affecting them;
- Recognition of the right of communities to manage their own health affairs and to further their development;
- Protection and promotion of the health interests and rights of minorities, special groups and marginalized communities, including those living in informal settlements and under-served populations;
- Promotion of social and economic development and the provision of proximate, easily accessible health services throughout the county; and
- Ensuring equitable sharing of resources targeting health delivery throughout the County.

Under the theme "towards attaining the highest standard of health"the goal of the policy is the attainment of the highest standard of health in a manner that is responsive to the needs of the population seeking health services in the County through visionary leadership and stewardship; Progressively Fair Financing; Motivated Health Workforce; Improved Health Infrastructure; Supply of quality-assured, efficacious and cost effective commodities and technologies; High quality and client-responsive service delivery, and; Robust and Reliable Health Information Systems for evidence based decision making.

The Policy seeks to deliver on two obligations on health: progressive realization of the right to health and contribution to development. There are three key outputs, each of which is underpinned by policy commitments namely:

- Improved access – adequate physical access to health and related services defined as living 5 kilometres from a health service provider where feasible; minimizing or removing financial barriers hindering access to health and related services; and guided by the concepts of Universal Health Coverage and Social Health Protection; and identification of socio-cultural barriers hindering access, and addressing them to ensure that all persons requiring health and related services are able to access them.
- Improved quality of care- positive experiences for clients during utilization of health and related services; effectiveness; quality management; national accreditation framework; regular review of standards of care and quality assurance;
- Improving demand for services in a responsive manner- clients/patients have adequate awareness of health actions needed to maximize their health; clients/ patients practice appropriate health seeking behaviour when threats to their health exist; clients/patients practice healthy lifestyles; clients/patients should be well informed of available services by the health provider.

(iii) Nyeri County Health Sector Strategic and Investment Plan 2013-2018

With the theme, Health for all, by all, the vision of the plan is an efficient and high quality health care system that is accessible, equitable and affordable for all while the mission is to promote and provide quality integrated preventive, promotive, curative, rehabilitative and palliative services to all Nyeri County residents. Its core values are accountability, partnership, teamwork, professionalism, and empowerment. Among its policy objectives are provision of essential health services and minimization of exposure to health risk factors.

Section 3 of the proposed Bill
See e.g. Sections 6-9 of the bill
Section 15 | Section 19-25 |Section 26

Chapter 4 | Survey Findings, Results and Discussion

The findings of the cross sectional survey is presented in relation to four aspects of the right to health: (i) availability, (ii) accessibility, (iii) acceptability (iv) quality. An analysis of the findings in relation to the service charters in the health facilities is also presented.

1.1 Availability

Availability of services refers to how easily required health services can be reached both physically and in a timely manner. Dispensaries, health centers and hospitals provide a range of preventive, curative, rehabilitative and palliative care services. The staff in charge of the facilities visited reported that the most common illnesses attended to by health workers were respiratory tract infections, skin conditions, rheumatism, arthritis, hypertension, worms, amoebiasis, diabetes and fractures as a result of accidents and assaults. Information on the availability of health services was obtained in relation to range of services offered and adequacy of information provided during a clinical consultation.

Availability of required services

More than half (57%) of the clients interviewed indicated that they had received all the recommended services.

Those who did not receive all the services recommended by the health worker said that this was due several obstacles including missing drugs and supplies (45%), absent health provider (10%), missing equipment (5%), missing services (5%), late arrival (5%) and queuing 5%.

Figure 6: Availability: Did you receive all services?

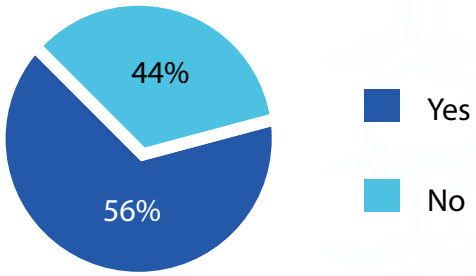
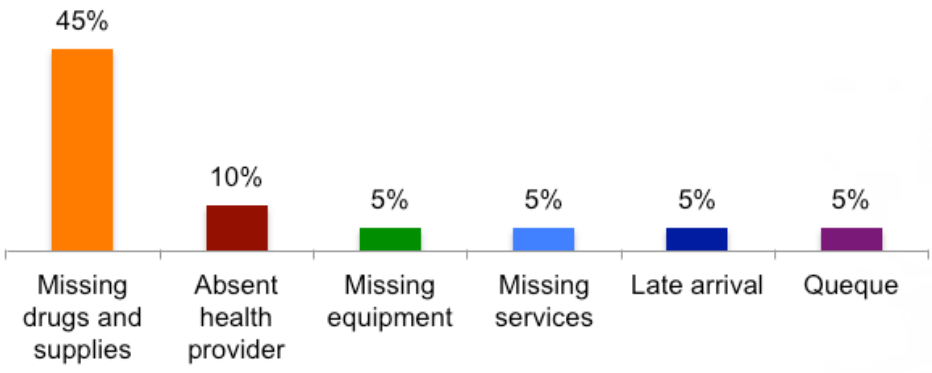


Figure 7: Obstacles to availability of health services



Of the clients (25%) who reported that they did not receive all the services recommended by the health worker, less than half (40%) were given other options where they could go to receive the services. When asked who would pay for the referral, slightly more than half (56%) said they themselves or their families would pay for their referral, 36% did not know who would pay for the cost of their referral and 8% said that the health facility would incur the cost of their referral. It is apparent that the needs of a large portion of the clients (46%) are not being met, mainly due to lack of drugs and supplies and absenteeism. The causes of the lack of drugs and health workers' absenteeism need to be critically analyzed and addressed.

Availability of condoms

When condoms are used correctly during vaginal sex, they help to protect against pregnancy and sexually transmitted infections (STIs) and should be widely distributed in condom dispensers within health facilities. It was observed that in the majority of the facilities (80.8 %) the male toilets and 84.6 % of the female toilets did not have stocked condom dispensers.

During a key informant interview with a policy maker, it was reported that an acceptable level of preventive, curative, rehabilitative services are available in almost all sub-counties in Nyeri County and a that good network of health facility infrastructure was in place. Residents take advantage of the availability of health services especially in Nyeri Town where the health seeking behavior of residents was viewed as good due to high literacy levels and economic status.

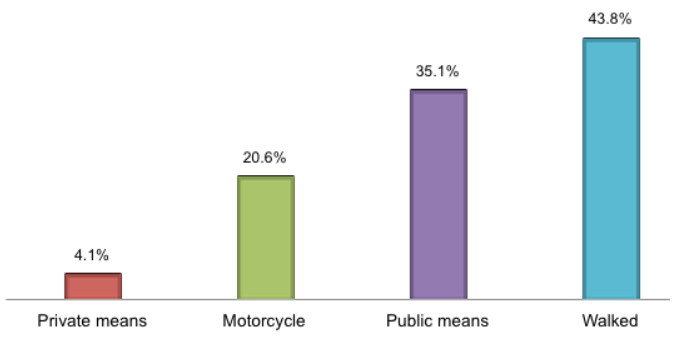
1.2 Accessibility

Accessibility of health services covers physical, geographic and economic aspects, including social and organizational dimensions, which enable clients to have access to information, staff, and identify which services exist. Services need to be reachable, staff approachable and clients' services without discrimination.

Physical access

In accessing health services, the physical location of the health facilities in relation to area of residence is crucial. Although clients used different and multiple means of transport, walking was the most frequent way of reaching the health facility (43.8%).

Figure 8: Mode of transport to health facilities



County Government of Nyeri(2014) Nyeri County Health Sector Strategic & Investment Plan 2013 - 2018 Department of Health Services

Amongst the clients interviewed 41.8% took between 15-30 minutes to reach the facility; 16.8% used between 31 minutes to 1 hour to reach facility; others (33.16%) used less than 15 minutes, and; 14.7% used more than an hour to access the facility. The cost of transport to the facility ranged from KES 0 – 200. Almost half (47%) of the clients said they did not incur any transport costs; 47% paid between KES 1-200, and; only 3% of the clients spent from KES 201-500 on transportation costs. Proximity was one reason why clients selected the health facility; this was corroborated by one FGD participants who said,

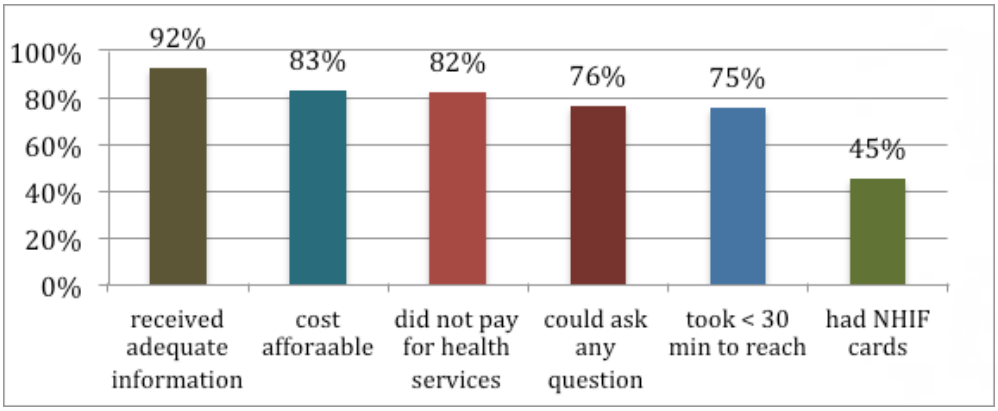
"The health center is near."

In general, the health facilities are "almost evenly distributed across the county". Almost all residents live less than seven kilometers from a health facility . Health services have been cascaded from the county headquarter to the level of the sub county, wards and community. Structures exist up to the level of community health committee and public health officers and technicians have been deployed within each sub-location. Another key informant said the distribution was "very good" especially when compared to Laikipia county. One key informant acknowledged,

"In terms of accessibility of health services, in Nyeri County, Wanjiku is currently being helped." Policy maker

Although health facilities are relatively accessible, difficult terrain and inaccessible roads increases the actual distance travelled.

Economic, geographic and information access



Access to information

When asked if the health care worker who had attended to them on that day gave them adequate information about their condition to meaningfully participate in their treatment, the majority of clients (92%) responded in the affirmative. When asked if they felt that they could ask the health worker in the facility any question if they don't understand anything about their care and treatment, 76% agreed that they could. Most of the clients (89%) believed that they were able to spend enough time with the health worker to discuss their needs.

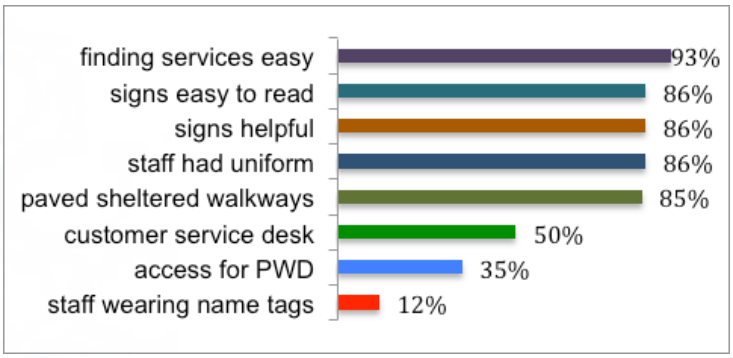
Physical access for persons with disability or injury

Access to the health facilities was a challenge for persons with disabilities or injuries. Only 34.6% of the health facilities were observed to have made efforts to facilitate appropriate accommodation, and installed ramps which would allow easy access for persons with disabilities or injuries. To provide shelter from rain, and facilitate easy movement, a large majority (84.6%) of the facilities had paved and sheltered walkways to all the departments.

Organizational access

Organizational access refers to the extent to which services are conveniently organized for prospective clients and encompasses issues such as clinic hours, appointment systems, waiting time and provision of information about services. Healthcare practitioners should treat their patients with dignity and adopt a client-centred care approach. This means that patients should be treated courteously in a way that respects their rights and autonomy. The way service providers communicate with health facility users is an important consideration. This includes how clients are received when they first meet them and at subsequent visits. Whether service provides wear name tags that clearly display their names and titles is important. How health workers introduce themselves to patients, children and their parents/caregivers who may not be able to read should be considered. These elements are part of organizational access. At each facility, information was collected on presence of customer service desks, signage, and whether staff were wearing uniforms and nametags.

Organizational access

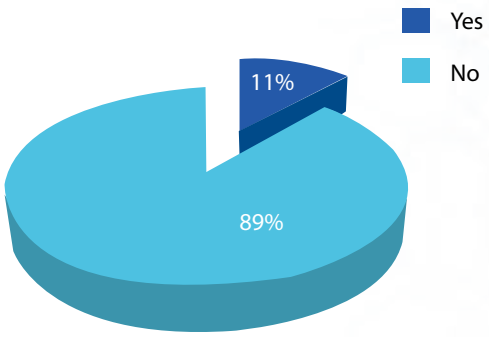


Customer Service or information desk – Customer service information desks are essential in all service industries. In all the health facilities observed only half (50%) had a customer service or general inquiries desk. It was found that the majority (92.3%) of the facilities had an established system for receiving clients that operated on a "first come first served" basis and prior appointments. Although many clients indicated that a system for serving customers was in place, the system does not work optimally. During the focus group discussions some community members complained that certain clients appeared to be favored and they sometimes felt that one had to "know somebody" to receive health services. It is therefore important that ways of continuously improving the client reception and service system are explored and implemented.

Facility signage - Almost all of the clients interviewed (93%) said that it was very easy to find the location of specific services needed in the health care facility. Most of the respondents (77%) said that they were familiar with the facility, while a few (16.8%), were directed by a member of staff. When asked if they have seen any signs or notices directing clients to where they should go for the services, the majority 85.7% said they had seen the signs. However when asked if they had understood the signs and notices 79% of the clients responded in the affirmative, 5% acknowledged that they could not read, while 2% said they did not understand the signs.

Access to staff through identification–Nurses, doctors, clinical officers and pharmacists routinely wear uniform when on duty. It was observed that in 88.5% of the facilities, staff could easily be identified through their uniforms. On the contrary, although it is a work requirement for health care professionals to wear name-tags when on duty, at the time of the survey it was found that only 11.5% of the health facility staff were wearing their name tags.

Figure 9: Are health facility staffs wearing nametags?



Waiting time: Most of the clients waited between 15-30 minutes before a health provider attended to them. More than half (60%) of the respondents said that they waited for less than an hour before receiving the services required, while 28% said they waited for between 1-2 hours before receiving the services required. Less than 10% waited between 2-3 hours.

Economic Access

According to national policy guidelines, primary care services offered in communities, dispensaries and health centers are free while services in hospitals attract user fees. On average, most of the clients (82%) reported that they did not pay for health services.

Table 5: Amount paid for services received

No	Payment	Number	%
1	Did not pay (free)	159	82%
2	KES 301-500	13	7%
3	KES 501-1,000	13	7%
4	More than KES 1,000	3	2%
5	KES 1-300	4	2%
6	Fee were waived	1	1%
	Total	**193**	**100%**

The proportion that received free health care varied according to the type of health facility. The proportion that did not pay for health services was highest at dispensaries (98%) and health centres (99%) and lower at the district (19%) and county referral hospitals (31%). This was consistent with the types of services provided at the different facilities and the Presidential directive that all maternity deliveries should be free of charge and the elimination of user fees at dispensaries and health centres. Health centres and dispensaries provide promotive, preventive, curative and rehabilitation services. Hospitals focus more on curative, surgical and inpatient services.

Table 6: Cost of Services by Category of Facility

Payment	Dispensary		Health Centre		District		Provincial		Grand Total	
	N	%	N	%	N	%	N	%	N	%
Did not pay (Free)	159	98	92	99	6	19	4	31	161	81
Don't Know	13	0	0	0	1	3	0	0	1	1
Fee were Waived	13	2	0	0	0	0	0	0	1	1
KES 1-300	3	0	0	0	4	13	0	0	4	2
KES 301-500	4	0	0	0	8	25	5	38	13	7
KES 501-1,000		0	0	0	10	31	3	23	13	7
More than KES 1,000		0	0	0	2	6	1	8	3	2
Total	**58**	**100**	**92**	**100**	**31**	**100**	**13**	**100**	**196**	**100**

The clients who paid for services used only two methods of payment: cash from self or family (12%) and using NHIF card 3%. There was little variation on the clients perception of the affordability of the charges levied on the services provided in the facilities varied; most of the clients (83%) said that the charges at the facility were affordable to them. One FGD participant testified,

"The costs of medicine are lower than in the private health facilities."

Amongst the clients interviewed in the facilities only 46% had National Hospital Insurance Cards (NHIF). Clients mentioned several reasons for not having registered with NHIF. Some said they were unable to afford the payments while others felt having the card was not important. A few said they did not have any information and were not aware about the NHIF card.

4.3 Acceptability

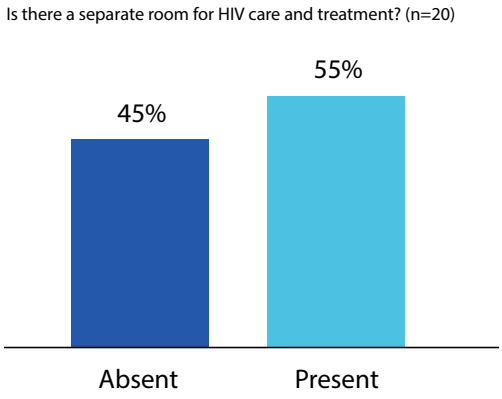
Elements of acceptability assessed during the survey involved obtaining insights into aspects of privacy and confidentiality of health services received and determining the level of satisfaction with services provided. Clients' views were obtained on whether or not they would recommend the facility to other family members and friends.

Privacy and confidentiality

An overwhelming majority (93%) of the clients reported that health providers saw them in private. This was validated by the observation that 96.2% of the clinical sessions in the health facilities were held in a private space such that consulting sessions, physical examinations and procedures could not be observed or be overheard by others. It was rare for a staff member to walk into the consultation room while clients were being attended to.

To have improved treatment outcomes, the nature of HIV care and treatment mandates that services be provided with utmost confidentiality. Nearly half (42.3%) of the facilities had a separate room or building for HIV care and treatment.

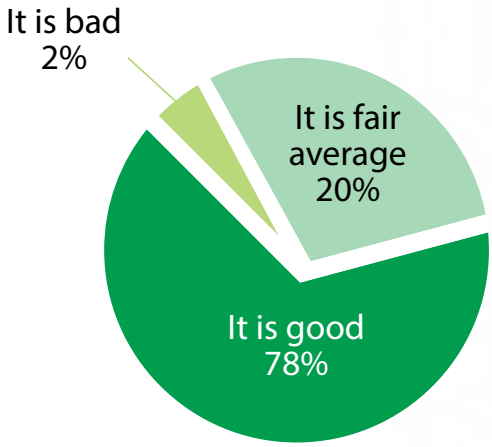
Figure 10: Availability of separate HIV care and treatment room



Satisfaction with services - quality

Almost all of the clients (93%) were satisfied with the services they received at the health facility on the day of the interview. When asked if they would come back to the facility if they ever needed any health care services in the future 93% responded in the affirmative. In addition, the majority of the clients (91%) interviewed said that they would recommend the facility to others in need of health care. When asked what they have heard from family and friends about the facilities over 90% said they had received positive messages.

Figure 11:Type of feedback from family and friends about facility



When asked to identify aspects they didn't like about the services offered in the health facilities the most frequently mentioned aspects were the deficiency of medication and supplies, inadequate staffing and lack of specialized care. In one focus group, when asked what challenges they experience when they visit health facilities, several were mentioned. One participant decried,

"The response is slow – when you go there after an accident they are not able to provide basic first aid".

Another explained,

"They make you wait a long time from 8am in the morning when you arrive, the doctor is not there".

Another FGD participant expounded,

"There is only 1 doctor"

Lack of consistency and disparities in service delivery were revealed;

"Some dispensaries are better than health centres, and they are better equipped with medicine and supplies and health workers. How is this the case?"

Some groups in the community that have difficulty accessing health care services were identified. Groups that experience difficulty in accessing services included the very poor or "maskini"; the unemployed; persons with disabilities, men who have sex with men and commercial sex workers. Although user fees may be absent, there are other barriers that come into play e.g. transportation costs, stigma and discrimination, and lack of awareness.

When asked what could be done to improve their experience and make it easier to use health care services, there were numerous suggestions. These included increasing the variety and quantity of medication and recruiting more service providers. Some recommendations were specific to facilities, including installing a mortuary to reduce the long distances need to travel to preserve bodies, installing surgical theatres, opening a newly built hospital and reversing the increased NHIF contribution from KES 160 to 500 per month. They said that everyone should be treated equally - one should not have to know anyone in the facility to be treated. They also suggested that clients should not be asked to buy gloves, dressings or pay for services that are free. A mechanism of screening those that are very sick and assisting them obtain preferential treatment to minimize their waiting time was proposed. The community members in the focus group suggested that "assessors" disguised as "patients" should routinely use the services so that they are able to experience for themselves what they go through.

Almost all clients (94%) felt that they were treated with respect by all staff and felt welcome in the facilities they visited. Much confidence was displayed on the skills of the workers,

"The health workers are professional and they know their work".

Another FGD participant further expanded this,

"When they give you a prescription the medicine usually works and the condition is treated".

Special groups

The Constitution specifically calls for taking into consideration the interest of special groups including children (Article 53), persons with disabilities (Article 54), youth (Article 55), minorities (Article 56) and older members of society (Article 57). In terms of infrastructure for child friendly services, very few of the health facilities had made special arrangements to welcome and accommodate the needs of children. Health facilities with child friendly amenities and processes were few and comprised only 23.1% of the facilities visited.

Within the County special groups facing impediments to full access to health services were identified. These are groups that require specific and tailored interventions for them to access services:

- Men who have sex with men – The gay community in Nyeri County is generally a concealed group of men who hide when they have meetings and use coded messages to communicate. The mainstream society does not recognize them and has failed to appreciate their unique health needs.
- Albinos – Although few, albinos have unique needs that are always not completely addressed in terms of skin creams and medications.

- Children with cleft lips or cleft palettes – the care givers of this small population needs to be mobilized so that they seek treatment for the condition and not conceal the children at home. Special programmes have been developed in the county to address their needs.
- People living with HIV – stigma is present amongst the community towards persons living with HIV; this is not unique to Nyeri County but exists throughout the country.
- Mentally challenged persons - have difficulty accessing health services. They are the ones who tend to have jigger infestation. This is a problem in families of the mentally challenged.
- Older persons – those that are staying alone without children to care for them are vulnerable.
- Street children – The lack of adequate attention and social perceptions of the problems faced by some street children in the community is an impediment to their realization of the right to health.
- Residents of remote areas - Although in general the county has a good infrastructure of health facilities, it was reported that in Kieni Sub County, due to the expansive nature of the region, community members are disadvantaged as they walk long distances to reach the health facility.

4.4 Quality

Aspects of quality of health services were described by the survey respondents in terms of the level of cleanliness of the health facilities, ease of use social amenities, quality of information provided and level of utilization of feedback from clients and staff.

Drinking water and hand washing facilities

It was pleasing to note that all the health facilities visited (100%) had clean drinking water for their clients. Slightly more than three quarters (76.9%) of the health facilities had functional hand washing facilities for outpatient clients to use immediately after visiting the toilets. In the inpatient department it was observed that less than half (46.2%) of the health facilities had functional hand washing facilities for clients to use immediately after visiting the toilets,

Toilets and bathing facilities

Most (88.5%) of the facilities also had separate toilets for males and females and 80.8% of the facilities had their toilets opened for use by their clients. Almost all the facilities (96.2%) had clean toilets and all the facilities of the client's toilets were well ventilated. The provision of toilet paper is the exception rather than the rule. The study team observed that only one facility (3.8%) provided toilet paper for use by its patients. The majority of the toilets (69.2%) did not allow easy access for persons with disabilities.

Incineration facilities

Health care services inevitably create medical waste in the form of infectious biological materials, chemical waste and sharps that are hazardous to health. Incinerators form a crucial component of environmental and health protection. The study found that that 69.2% of the facilities had an incinerator to use for the disposal of medical waste. It is important to ensure that all health facilities have the appropriate equipment for management of medical waste.

Feedback from clients and staff

Also most of the facilities (73.1%) had in place a mechanism of obtaining feedback from clients and staff through a suggestion box.

Cleanliness

Almost all of the health facilities (96.2%) were adequately clean and free of unpleasant smell. In almost all the facilities (96.2%) the waiting areas for clients were clean. All the waiting areas were well ventilated and sheltered. It was also observed that 96.2% of the clients' waiting areas had enough seating for all clients. For the in-patient clients, in most of the health facilities the food was prepared in a clean environment and was palatable.

In the focus groups community members were asked what they felt was being done right in the health facilities that should continue. Some said,

"The buildings are nice".
Another remarked,
"The place is clean".

Appreciating the multifaceted nature of the challenges facing the sector, more than one key informant emphasized that a holistic approach be used to manage health service delivery as a system; there should be systematic improvement and application of policies, procedures and practices to the seven components of the health system: human resources, medication and supplies, financing, information systems, service delivery, governance and infrastructure.

Participation and involvement

Despite the Constitution requiring citizens to participate, many community members felt that their level of participation and involvement was inadequate and could be improved. Focus group discussion participants made several suggestions on ways the health facilities could better involve community members in decision-making. One way was through developing and implementing a more transparent process for one to become a community representative of the health facility management team.

Another way of increasing participation and involvement was through using a well-managed suggestion box for community members to communicate ideas and complaints. Mechanisms of managing the information should be honest and the importance of communication highlighted in the service charter. There should be a telephone number provided through which clients could send information. More dialogue and discussions should be encouraged between the clients and staff at the health facility. Mechanisms

of increasing dialogue are through outreach activities and open days, which draw people near. Through these events community should be made aware of how the health facility works and how one can become a member of the health facility committee. For accountability and to ease communication, the head of the institution – the name of the person to talk to – should always be displayed.

4.4 Service Charter

Observations conducted in the health facilities revealed that from 50 - 92.3% of the facilities had a service charter. The service charters were displayed in a prominent location where anyone walking into the hospital could see and read them. Only 77% of the facilities indicated what times the services were available as well as what the services cost. Information in the facility service charter is communicated to clients mainly through posters. Verbal and recorded messages are rare.

Almost all the health workers interviewed (99%) thought that each health facility should have a service charter, as they felt it was an important method of communicating information about the health facility. The staff reported that the information contained in the service charter described the range of services offered, cost of services, expected time taken to receive services, client's rights and responsibilities and staff rights and responsibilities. Less frequently mentioned were the mission and vision of the hospital, how clients should be managed and referrals.

During interviews with the health workers, it was found that information relating to the service charter is communicated in almost similar fashion to staff and clients. Information in the service charter is communicated to staff through multiple channels; mainly using posters, during staff meetings and one on one sessions. When health workers were asked if they felt that all the clients understand the information in the facility charter, slightly more than half (51%) replied in the affirmative.

Concerning the information to be included in the facility service charter, the staff were of the opinion that information on rights and responsibilities of client and staff, services offered, cost of the services and duration of services, should be icluded. Staff recommended the following should be done to ensure that all clients understand the information in the service charter: information shared to be simplified, expressed verbally and translated to different languages.

An analysis of the service charters showed that they displayed the name of the facility, a logo and name of the charter. A large majority of the service charters stated the mission and vision of the facility as well as the moto in Kiswahili "huduma bora ni haki yako" (you have the right to good service). Other information contained in the charter included the official operating days, time of operation and the visiting time. A list of the services offered and their related costs were often provided. The services that were provided for free were often prominently displayed. Frequently the duration within which services were to be offered were specified. Contact telephone numbers were rarely provided. Most common languages within which the service charters were communicated were English and Kiswahili. Less frequently the local languages Kikuyu, Kikamba and Luhya were used. Occasionally information to promote good governance was provided such as "it's a corruption free zone".

Figure 12: Ichagiciru Dispensary Service Charter

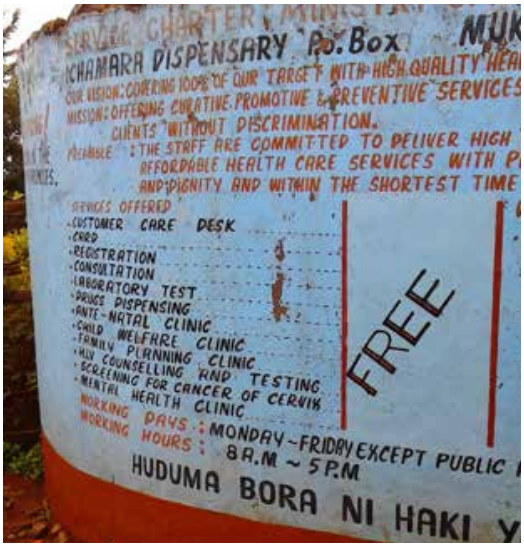


Figure 13: Ichamara Dispensary Service Charter

Figure 14: Kangocho Dispensary Service Charter

Figure 15: Kiganjo Health Centre Service Charter

Chapter 5 | Conclusions and Recommendations

5.1 Conclusions

Nyeri County has made major strides towards realization of the right to health. Several county specific policies are in place to guide the delivery of health services. The county has demonstrated leadership in enacting the Nyeri County Health Act in July 2015, which is the premier legislation guiding health service delivery in the county and based on the tenants of the Constitution.

The availability of health facilities is above the country's norms and standards and health facilities are easily accessible to residents in terms of physical and economic access. Although the county has numerous health facilities and infrastructure above the national norm, missing drugs and supplies and absent health workers are the main obstacles to receiving optimal care.

The services were culturally acceptable; clients feel they are treated with respect by all staff. Clients feel welcome in the facilities and displayed confidence in the skills of the health workers. The health services were of high quality in terms of the level of cleanliness, water and sanitation of the health facilities, ease of use social amenities and level of privacy and confidentiality. The level of client satisfaction was high and clients perceived that the quality of information they received was good. With regard to minority groups, strides have been made in addressing increasing access and involvement of persons with disabilities. Health workers have been trained in sign language and persons with disabilities are involved in health facility management committees.

There is a degree of discordance between the reported high level of client satisfaction (93%) and the low proportion of clients reporting they had received all the recommended services (57%). In this situation, a lower level of client satisfaction would be expected. The high level of satisfaction may be due to low expectations from the client, imbalance in the power relations between clients and health workers or clients lack of knowledge on their rights.

5.2 Recommendations

In order to provide health services that are fully compliant with the Constitution and integrating the national values and principles and utilizing the rights based approach, the following recommendations are made:

1. Improve Supply and Management of Medication - Shortages of medication and supplies were consistency mentioned as issues that needed to be addressed. Effective ways to improve on the supply of drugs need to be identified, implemented and monitored.

2. Improve Efficiency and Effectiveness of Human Resources - The County Government should work to improve the efficiency and effectiveness of health workers and identify ways to enhance motivation. Some of the areas requiring improvement and could significantly improve service delivery include regular opening hours, wearing of uniforms and name-tags. Ways to supervise health workers to ensure they maintain positive attitudes and treat the clients and their colleagues with respect should be reviewed and monitored. The county should ensure that there is minimal absenteeism of health workers to facilitate service delivery.

3. Increase Financing to Health Sector- The national and County Governments should collaborate to identify ways to increase allocation of funds to the health sector to reach the 15% recommended by the Abuja Declaration. This will enable the National Government and Nyeri County Government to provide adequate and quality health care to its citizens and residents.

4. Strengthen Referral systems- For the services that are not available at a facility, health workers should give options on where they could go and receive the services. There should be clearly laid down mechanisms on referral of clients to other health facilities. These should include transport costs e.g. payment of ambulances during the times of referrals and during emergencies.

5. Increase numbers of clients registered with NHIF - The numbers of people enrolled in National Health Insurance Fund stands at 46%. This is higher than other counties however it is still very low. The County Government in collaboration with NHIF should develop strategies to raise awareness on insurance coverage through NHIF and thereby increase registration in the county.

6. Improve efficiency in use of ambulances and provision of emergency services- There appeared to be lack of clarity on fees and mechanisms of utilizing ambulances. Respondents complained about poorly equipped ambulances for referrals. Some health care facilities are not always ready when life-threatening emergencies occur. Guidelines should be developed to help facilities prepare for medical emergencies so that if one occurs the best possible life saving techniques and equipment will be available to save the patient. The guidelines should stipulate when and at what time the client should pay for the services rendered. The ambulances for referral should be centrally located to facilitate the ease of access and reach to other facilities in the County. Whether the ambulances should be located at County hospitals or at health centres should be determined. The County should ensure that the ambulances have all the necessary equipment, personnel and fuel to facilitate referral of patients.

7. Improve Information, Education and Communication - Clients need to be empowered to actively and meaningfully participate towards attaining the rights based approach to health service delivery. Health care workers, the media and civil society together or separately have a duty to empower clients through information communication and education. Communication efforts must be anchored in a genuine desire to share information truthfully and accurately with the objective of enabling clients to meaningfully participate and make informed decisions on their own health care. Media and communication strategies should encompass sharing success stories, branding, resource mobilization, innovation and use of technology,

8. Take Advantage of Technology – Most people in Kenya either have or have access to mobile phones and there are numerous applications that have been developed to improve access, availability, acceptability and quality of health service delivery. The potential of technologies such as mobile phones and computers to improve service delivery should be explored. Possible services include mobile phone consultation and working with communities.

9. Increase Access to Services for Marginalized Groups - Although the national Government and the County Governments are working to ensure that minority, marginalized, and vulnerable groups have adequate access to health services, more needs to be done in terms of capacity building to help the staff offer quality services and reduce stigma and discrimination, and hence increase access to services.

10. Improve Services for Persons with Disabilities - It is commendable that the Nyeri County Government is conducting a registration of persons with disabilities in order to have information for planning. Mechanisms to ensure the persons with hearing, visual, physical and intellectual impairments are able to access services should be designed and operationalized. Health workers need to be trained especially on sign language, to provide adequate and quality services to the hearing impaired. The civil society should also work with the County Government and the national Government to ensure that the service charter is provided in audio and braille formats so that the visually and hearing impaired members of the society can be able to read and know what it entails. The Persons with Disabilities Act mandates all buildings to enable access for persons with disabilities in the form of ramps, elevators, etc. This will enable easy movement of people with visual impairments, crutches, wheel chairs and the elderly. All buildings should abide by this. Systems should be put in place to ensure that future construction and renovations take into consideration the needs of persons with disabilities.

11. Strengthen the Health Facility Management Committee–Guidelines for the selection of the health facility management committee have not been revised with devolution of health care. This committee has great potential to improve the service delivery at facility level. The mechanisms through which this committee is appointed and how effectively it operates should be reviewed and enhanced.

12. Enhance Operational Documents e.g. Service Charter - Apart from policies, guidelines, and standard operating procedures, the health service charter is an important operational guiding document. An analysis of the 26 health facility charters showed the messages contained different information including the name of charter, name of health facility, logo, mission, vision, moto "huduma bora ni haki yako ('the provision of good services is your right)", rights and obligation of clients and health workers; a description of the services that are free; days and hours opened; visiting time; charges; time expected for services to be offered;, statements that it's a corruption free zone, and; contact telephone numbers.

13. It is recommended that the County Government apply the charters developed under this project and continually review them to ensure that they all apply the standard minimum content that should be contained and displayed in a service charter. The language and mode of communication should also be expanded to reach different languages of the clients and cater for the needs of persons with disabilities.

14. It is recommended that the service charters focus on the rights and obligations 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. To increase authenticity, the service charter should be embossed with the county logo.

15. In an effort to catalyze behaviour change for health workers to espouse a culture that is compliant with the Constitution and promote a rights based approach to health service delivery, it is vital that the level of awareness of the health workers on the contents and expected behaviour described in the service charter is increased. Power relations need to be improved. Clients approach facilities and health care providers from a point of vulnerability and are therefore disempowered and disadvantaged. Clients and community members need to be empowered to claim their right to health through participation and provision of adequate information. Deliberate actions to communicate the contents of the service charter to all health workers within a facility should be taken. This can be done through multiple channels such as brochures, posters, during staff meetings and one on one sessions.

- It is recommended that the reviewed sample service charters under this project be used to change the current charters and to provide guidance on the standard the minimum content for health facility charters. The minimum content of the service charter should inform clients what they can expect from healthcare services in public health facilities, and where to go for help if they have concerns about the service that they are seeking or receiving.

- To ensure that all clients, including those who have been traditionally excluded, like those with visual and hearing impairments, the illiterate, those who cannot read English, 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 different local languages used in the county.

- Two samples of a comprehensive and abridged Service Charter that health facilities can use have been developed based on evidence obtained from the document review and consultation with clients, health service providers and public health officials in Bungoma, Kitui and Nyeri counties.

- 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 and responsibilities, while the clients as the rights holders have certain rights and responsibilities for their own health care. The contents of the proposed service charters may spark questions, comments and clarifications from clients. Service providers should welcome this conversation and be prepared to answer questions and address the issues clients raised.

County Government of Nyeri
Ministry of Health

WELCOME TO: .....

HEALTH FACILITY SERVICE PATIENT CHARTER

YOUR RIGHTS

- To receive appropriate, timely health care, including emergency treatment, without discrimination.
- 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 the right to freedom from torture, cruel, inhuman and degrading treatment while under the care of the health care facility.
- To the right to bodily integrity and security of your person while under the care of health care facility.
- 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 be served courteously, compassionately, and with respect.
- To be served in a way that respects your privacy and right to confidentiality.
- 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 continuity of services, referral, follow up and advice necessary for your healthcare
- 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.
- To a clean and safe environment within the health facility.
- To freely express your complements, comments and complaints about the care you receive.

YOUR RESPONSIBILITIES

- To follow and abide by the health facility's policies, regulations, processes and to complete any forms as required.
- 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 treat healthcare professionals, authorized staff and other clients with respect and dignity.
- To provide the healthcare professionals with accurate information about your health and to ask questions to clarify what you don't understand.
- To follow the prescribed treatments, rehabilitative procedures and follow-up care.
- To sign against your decision to decline any treatment recommended by the health facility.
- To make only authorized payments for services that require payment and obtain official receipts and to inform management of any irregularities.

Hours of Operation:

Monday-Friday: ..... To .....

Saturday-Sunday: ..... To .....

Public Holidays: ..... To .....

Our Contacts:

FACILITY NAME: .....

Email: .....

EMERGENCY TELEPHONE CONTACTS: .....

FEEDBACK: .....

TELEPHONE CONTACT: .....

Help us to help you

Give suggestions on how we can serve you better and how you can assist us to serve you better.
You may submit any complaints regarding the services you have received. We promise to look into the matter and revert to you.
To improve the operations of the facility, this charter will be reviewed from time to time after public and stakeholder consultations.
We promise to subject your complaint to a fair and due administrative process for yourself and any person involved in the matter.
Please also read the full charter as provided in booklets in our waiting areas.

Embassy of Denmark
DANIDA | International Development Cooperation

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

County Government of Nyeri

DEPARTMENT OF HEALTH SERVICES

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