County Government of Bungoma

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 Bungoma County Health Facilities

Submitted by:
The Commission for the Implementation of the Constitution (CIC)
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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, among other things, monitoring, facilitating and overseeing the development of legislation and administrative procedures required to implement the Constitution.

In discharge of its mandate, CIC guides the national and County Governments in the process of 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 Bungoma undertook a project of evaluating the operational frameworks of the health facilities in Bungoma County with a view to identifying ways of ensuring that the County complies with its constitutional mandate of facilitating the respect, promotion, protection 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 the frequent media reports on the negative treatment of patients seeking health services in different public health facilities around the country. Various forms of human rights violations have been reported including physical and verbal abuses, mistreatment and harassment, neglect and abandonment, humiliation, punishment and detention of patients in health facilities for failure to pay hospital bills, among others. The evaluation project was supported by the Danish International Development Agency (DANIDA) and had the key objectives of:

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

(ii) Reviewing the county health facility service delivery charters to align them with the constitution; and

(iii) Developing 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.

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

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

Signed:

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

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Acronyms

ACHPR	- Africa Charter on Human and People's Rights
CEDAW	- Convention on the Elimination of All forms of Discrimination Against 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
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
PLHIV	- People Living with HIV/AIDS
PWD	- Persons with Disabilities
RBA	- Rights Bases Approach
UDHR	- Universal Declaration of Human Rights

Acknowledgement

This baseline assessment study was undertaken by the Commission for the Implementation of the Constitution (CIC) and the County Government of Bungoma, with support from DANIDA. It involved various stakeholders who participated and provided invaluable information that enriched the report: we sincerely want to thank them for their contribution. We also wish to acknowledge the survey respondents from all over Bungoma County - Mt. Elgon, Cheptais, Sirisia, Kabuchai, Webuye, Kanduyi, Kimilili, Tongaren and Bumula Sub-Counties – for their cooperation in providing information that formed the basis of this report.

The national oversight committee helped in the quality control of the process, and provided professional guidance at all levels and stages. This committee was made of representatives of the Ministry of Health from 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, and a media representative. Also involved was the Bungoma County project oversight team comprising of representatives from the County Government

We thank the project's public health and human rights consultants, Dr. Ken Manyonyi and Dr. Ruth Aura, who worked tirelessly to ensure completion of this project. We are also grateful to the communication consultant, Mr. Mburugu Gikunda, for audio-visual documentation of the process; the project administrator Ms. Veronica Omunga for organizing and coordinating the different project activities; and the CIC team led by the Chairperson of the Commission Mr. Charles Nyachae, who participated in the different project activities, and provided insights that guided the different stages of the project.

In particular we are grateful to the CIC project team led by Commissioner Catherine Muyeka Mumma, Dr. Florence Omosa, Mr. James Wagala, Mr. Mr. Mugita Gesongo, Mrs. Christine Kuria, Mr. Ahmed Anwar and Ms. Ruth Muthui, for their professional guidance at every stage of the project, their participation in most of the processes and their review of project outputs.

Executive summary

The Constitution of Kenya 2010 ushered in a new era of a strong Bill of Rights guaranteeing the civil and political rights and freedoms, economic, social and cultural rights and environmental rights. Everyone is guaranteed the right to the highest possible standard of health including reproductive health care. The constitution has a number of other provisions supporting the right to health. Apart from the substance of the rights, the constitution has also set high standards of values and principles, which bind all public offices and officers as they undertake their mandate. The health function is one of the devolved functions, with the National Government having been assigned responsibility for the development of national policies and laws; the provision of technical support to County Governments; the setting of standards for guiding service delivery in the health sector; and the running of national referral hospitals. The counties, on the other hand, have been assigned the bulk of health service delivery and the running of county health facilities among other responsibilities.

Against the high expectations of this new dawn, there have been some media reports highlighting incidents of violations of the right to health at various health facilities. This brings to doubt the possibility that the responsibility to integrate constitutional values and principles in service delivery is well appreciated by those in charge of health facilities at the national and county levels. It is against this backdrop that the Commission for the Implementation of the Constitution (CIC), and the County Government of Bungoma agreed to partner in a project to determine how the county health facilities in Bungoma can work towards the implementation of their responsibility to integrate the necessary values and principles, including the rights based approach, in health care for better service delivery.

MANDATE OF THE CIC

The Commission for the Implementation of the Constitution (CIC) is mandated to monitor, facilitate and oversee the implementation of the Constitution, while also monitoring the effective delivery of the system of devolved government. The Commission's strategy focuses on ensuring policy and legislative frameworks are compliant with the letter and spirit of the Constitution, plus effective institutional and administrative procedures for the implementation of the Constitution. CIC approached the County Government of Bungoma to request for a joint project to incorporate Constitutional values and principles in health service delivery through a rights based approach. At the start of 2015 the project kicked off with Bungoma being one of three selected pilot counties (alongside Kitui and Nyeri), .e The main aim was to initiate a process of positive transformation of a service delivery culture in county health facilities towards a rights respecting, inclusive and non-discriminatory, accountable environment with diminished violation of human rights.

PROJECT OBJECTIVES

The overall objective of the project was to review the operational frameworks of Bungoma county health facilities against the Constitution, evaluate their strengths and weaknesses and make recommendations on how the County Government of Bungoma can integrate the values and principles of the Constitution and the rights approach to service delivery in their health facilities. The specific project objectives were to:

(a) Audit the service charters of county health facilities against the Constitution, review and align them to the constitution;

(b) Audit the county health facility operational frameworks including the policies, regulations and guidelines, management tools and the service delivery cultures. Recommendations would be made on how

they can be improved upon, integrating the values of the constitution and the rights based approach to service delivery.

(c) Develop the capacities of the County's health sector teams on the right to health in the constitution, and the implementation of Article 10 and the rights based approach to service delivery.

(d) Document the project process as a way of guiding any other county or stakeholder that might want to undertake a similar process.

PROJECT STEPS

CIC developed a concept note to seek funding for the Project from DANIDA once Bungoma County communicated its willingness to pilot the project. DANIDA, which is a strong supporter of human rights approaches to programming and services not only agreed to support the project, but also advised on the inclusion of another two counties to widen the pilot. CIC then began the project activities in the last quarter of 2014 with the recruitment of project consultants and establishment of the project oversight committees. The consultants included a public health consultant with knowledge on health systems and a human rights expert with knowledge on rights based approaches. A communication consultant was also hired to develop with the documentation. A county project coordinator was appointed by the County Executive Committee (CEC) Member in charge of health and an oversight committee comprising of representatives of different stakeholders in the county was established to guide the consultant team on its work

An inaugural workshop was held on 16th and 17th February 2015 in Sagana to sensitise the leadership of all three project participating counties, the national oversight committee, the county project coordinators and the consultants on the constitutional expectations with regard to the right to health, health as a devolved function and the obligation on applying values and principles in service delivery. The teams were also trained on the rights based approaches to service delivery.

Inaugural county capacity building workshops were then held in Bungoma from 23rd to 25th March 2015, involving health service providers and managers from both public and private sector, as well as representatives of the civil society organizations and media. The workshops were a combination of the topics on the right to health and the constitution. However, the training was done separately for the county health sector team and the non-state actors to allow free expression of either group on the issues they felt affect the county health facility systems. The final day of the workshops brought the two teams into a plenary to discuss each other's perspectives.

The next activities included the development of the health facility assessment survey tools, the training of research assistants and the pre-testing of the tools, which was done jointly with the two other counties. The data collection was done with the assistance of nine research assistants identified by the county health team.

Extensive baseline data was collected from various levels of the Bungoma County health facilities in May 2015 and subsequently, the data was collated, cleaned, coded and analysed. The first draft of the county report and the first draft county health facility broad charter was then developed and presented to the national oversight committee in Nairobi on 10th August 2015. After the review of the draft report and charter on the basis of the national oversight committee views, a second draft was presented to Bungoma county stakeholders on 17th August 2015. The final report and charter were then developed, taking into account the views of the county stakeholders.

A summarized version of the charter was then developed to guide the County on the provisions that may be adopted for display in the health facilities. The summarized charter was then translated into Kiswahili, Sabaot, Teso, Tachoni and Bukusu languages in recognition of the main different communities that live in Bungoma County.

ABOUT BUNGOMA COUNTY

Bungoma County covers a surface area of just over 3000km2 and has an estimated population of 1.7 million, with 46 percent of that population aged below 15 years. Among its numerous structures built for health service delivery, 10 Hospitals, 16 Health Centres and 88 Dispensaries are functional. These are distributed across its nine sub-counties and are complemented by 268 Community Health Units.

ASSESSMENT METHODOLOGY

The assessment involved the review of relevant policies laws, health facility operational frameworks and tools and a rapid assessment of a sample of county health facilities through key informant interviews with different stakeholders, including health sector policy makers, health facility staff, and members of the community, civil society and other non-state actors.

The rapid baseline assessment combined both qualitative and quantitative methods to create a 'before' portrait of health service delivery as the benchmark. The purely qualitative methods comprised of a systematic review of selected relevant documents, 7 Focused Group Discussions, 11 Key Informant Interviews and 52 Health Facility Observations. The quantitative and the mixed methods utilized purposive sampling of the health facilities in Bungoma County from the Master Facility List to include various levels. The Primary stratum was Bungoma County while the secondary strata were its nine sub-counties from each of which was selected 1 hospital, 1 to 2 health centers & 4 to 5 dispensaries, based on the respective population catchment. Three tools were used for the health facility assessment - Client Exit Interviews, Health Facility Staff Interviews, and Health Facility Observation.

Qualitative data was analysed thematically and quantitative data by use of SPSS (Statistical Package for the Social Sciences). The findings were triangulated to create a 'before' picture, with regard to the responsibilities and obligations of the public Health Service System. The findings were summarized under six sub-headings:

a. Awareness of the Right to Health;
b. Availability of Primary Health Services;
c. Accessibility of Primary Health Services;
d. Acceptability of Primary Health Services;
e. Quality of Primary Health Services; and
f. Other Considerations of relevance to ensuring positive change in work culture.

The 'Before' picture of health services in Bungoma County was used to guide the revision of the service delivery charters for the health facilities at various levels in order to bring them in line with the right to health as enshrined in the Constitution of Kenya 2010.

NOTED BEST PRACTICES IN BUNGOMA COUNTY

Notable best practices in Bungoma County public health services comprised a number of actively functional Community Health Units offering Level 1 services that positively impacted on the services provided at corresponding link health facilities; and the highly professional staff manning the various Comprehensive Care Centres (CCCs), who were cited for their responsiveness, efficiency and sensitivity to the needs of people living with HIV. In addition, young people at Chwele Youth Friendly Service Centre displayed remarkable awareness of the right to health, and reported better access to reproductive health services as a result. These three examples present an opportunity to craft a more robust, participatory approach to improved health services

FINDINGS ON AWARENESS OF RIGHT TO HEALTH

The project was carried out in full realisation of the fact that Kenya is in transition from the centralized to the devolved system of governance, a situation bearing multiple challenges - including the lack of capacity among staff at both levels of government, on the operational protocols to apply for the implementation of health as a devolved function.

The levels of awareness on the right to health was found to be nominal within the health facilities, with the existing service delivery charters at various health facilities being inadequate and impractical in addressing the human rights aspects of health service delivery and the needs of special interest groups. The service charters had been developed by the former central

government from a standard template, which merely stated the type of services that were to be delivered and indicated both the period of time it would take to provide the service and the cost of the service. Whereas the 'charters' provide some information on the availability, cost and anticipated time of receiving commonly sought services, they excluded so many other concerns relating to service delivery and the rights of those seeking such services.

Bungoma County had not developed any county-specific health policies or regulations to guide operations at its health facilities. Staff at the facilities were largely operating within the practices that prevailed before devolution, making reference to the pre-existing guiding tools and the practices as adopted before devolution. The financial allocation to health seemed to overlook the need to invest in management and coordination expenses for the county health structure and facilities. There were no county-specific circulars to guide health workers. No Terms of Reference had been issued to the sub-county health managers. Community members termed the right to health a dream, even as health workers cited various hurdles to achieving high standards of health services.

FINDINGS ON THE AVAILABILITY OF PRIMARY HEALTH SERVICES

Whereas most of the health facilities visited had some level of functionality, scarcity of staffing of different cadres of health professionals and other supporting staff was reported, and clearly there was need for medical equipment, commodities, drugs and other supplies to optimize the provision of health care to more people. Some specialized services including rehabilitative, mental and other disability-specific health services were virtually lacking, indicating a high level of exclusion of persons with disability from the services offered. None of the health facilities visited had achieved the minimum standards of health staffing as prescribed by the Ministry of Health prior to devolution of health services. In some parts of Bungoma County, such as Mt. Elgon Sub-County, the average distance to the nearest public health facility exceeded the recommended 5km, and overall there was inequitable distribution of functional Level Four health facilities and of senior cadres of health personnel such as doctors and various specialists.

FINDINGS ON THE ACCESSIBILITY OF PRIMARY HEALTH SERVICES

Financial, non-financial, structural and organizational barriers determine access to the available health services in the County. Slightly less than 50 percent of those interviewed stated that they had walked to the facility, indicating good access, especially the dispensaries. Over 50 per cent of clients accessing services at various public health facilities in Bungoma County incurred costs on transport and for various routine aspects of service provision, with most clients paying for one aspect or another of the services accessed, even where such services are officially termed free. Examples would include payments for registration or the opening of a card or file, consumable items such as gloves, prescribed medications, or for various other routine aspects of service provision. Unfortunately, fewer than 50% had difficulty regarding payment for services, with many expressing inability to raise some of the costs demanded.

Non-financial barriers, as exemplified by basic communication hurdles for people with disability (PWD), particularly those with hearing disability, plus the general lack of simple and straight-forward information regarding available services, hours of service provision and corresponding costs, were observed at 40 per cent of public health facilities. The effect was clients got disappointed when they went to a facility expecting to receive a service that turned out not to be available, and instead get referred elsewhere. For emergency cases, this could be costly.

There was widespread lack of use of name and official designation tags by health workers in the facilities, meaning that a client may not be able to identify who is staff, for some cadres of staff and who is serving them. Special interest groups

especially teenage mothers, PWD, drug users, Female Sex Workers and Men who have Sex with Men seemed not to be catered for.

FINDINGS ON THE ACCEPTABILITY OF AVAILABLE HEALTH SERVICES

The vast majority of exit interview respondents had been treated respectfully by staff at the health facility. There was systematic review of clients (on a first-come-first-served basis), with over 90 per cent reporting adequate privacy, confidentiality and overall satisfaction with the way they had been handled. However, at a focus group discussion, PWD commented that they often got embarrassed by health workers in the facility and that they were often by-passed by the able-bodied clients when seeking health services. In addition there were reports of special consideration for persons known to the health staff, or to senior government officials would receive preferential treatment such as by-passing the queues. Health providers also reported the tendency by politicians to breach the protocol and require expedited handling of patients related, or in some other way connected, to them.

PLHIV commended staff in the Comprehensive Care Centers for being efficient, considerate, ethical and professional, in contrast to staff in other departments at the same facilities whom they described as being discriminatory, unethical, unprofessional and inhumane. For example they reported frequent delays as well as instances of coercion of HIV positive women to accept surgical sterilization when they needed surgery.

Representatives of women's groups reported that health workers in Mt Elgon sub-county commonly fail to provide proper management of sexual and gender based violence, usually to the detriment of many rape/defilement victims, while Community Health Workers lamented that health workers tend to treat patients according to their socio-economic level – prioritizing those seen as being financially better-off whereas the poor would most likely be ignored.

FINDINGS REGARDING THE QUALITY OF THE AVAILABLE PUBLIC HEALTH SERVICES

In contrast to the overall satisfaction by exit clients who were interviewed at various health facilities, perceptions among a variety of respondents in the community highlighted that "the most important drugs are often out of stock"; and that they frequently used unsupervised 'trainees' to care for patients, who consequently felt that they did not get quality services. Regarding one of the hospitals it was stated that it was "common for operations to be repeated due to errors in the first instance". Concern was also raised over frequent absenteeism among health workers and that those reporting on duty tend to "come late, take long breaks for tea and lunch, even if there are patients waiting to be served, and they leave early to go back home".

While most health workers felt that services offered at their health facility were good, 73 percent noted that the lack of drugs and supplies made it difficult to provide quality services; 43 per cent felt that greater investment in laboratory and diagnostic services was required to improve services; 35 per cent highlighted the problem of under-staffing as a key factor hampering the quality of health services; and 32 per cent noted the need to improve inpatient services.

At a number of health facilities visited a review of the sanitary facilities surprisingly found that the client toilets were locked, or that they were open but not clean. Additionally those facilities lacked functional hand washing facilities for use by clients after vising the toilet. In all facilities visited, there was no easy access to toilets for PWDs, and neither was there any toilet paper for client's use.

IMPLICATIONS FOR THE COUNTY GOVERNMENT

While Health Facilities exist almost everywhere in Bungoma, 77 percent are dispensaries that are open 8am to 5pm on weekdays, meaning that they remain closed from 5pm to 8am and also throughout the weekends and public holidays. Essentially, for most people in Bungoma, the health services are available only 33 percent

of the time. With a poverty index of 53 percent, financial hurdles effectively lock out the majority of Bungoma residents from accessing primary health services. There are equity concerns, more so for the population residing in Mt Elgon Sub-County, where on average the distance to the nearest health facility is longer than the recommended 5km and the situation is made worse by the poor state of the roads.

The signage at the health facilities was not facilitative in easily guiding service seekers and generally one had to enquire and be directed. The lack of public information on most of the available services and the corresponding official charges at most of the facilities observed effectively opened a loop hole for unauthorized charges as reflected in the statement: "Except for registration, receipts are hardly ever provided for the payments made for services."

The Bungoma health system appears to restrict service availability and, by default, fails to cater for the basic needs of various recognized special interest groups. Failure to address the fundamental needs and concerns of such special interest groups deters them from seeking services in the public health system, with serious consequences particularly for those who cannot afford private services.

The lack of a formal regular feedback system had resulted in disquiet and dissatisfaction among health personnel and a notably diminished staff morale, which negatively impacted upon service provision. Further, the sub-optimal involvement of clients in their care, makes them into passive recipients of the prescribed treatment.

The media has highlighted instances where patients in Bungoma have been treated inhumanely. Notably, there was feedback from community groups that often the affected patients refrain from complaining out of fear that this may have a backlash or repercussions to them in future.

STAFF CONCERNS

Staff hesitated, at the beginning, fearing possible victimization for raising concerns, but were assured that the County Government had a resolve to improve services and as such would not victimize any member of staff.

Most of the facilities did not have formal, a regular internal feedback system on the operational procedures, work culture and concerns by the different cadres of staff. This has led to disquiet and dissatisfaction among health personnel and a notably diminished staff morale, which negatively impacts upon service provision. Most health facilities did not have a designated budget and means to support the management of services by those heading the facilities resulting in dejection and sub-optimal management of the county health services. Often times, facility heads were not involved in the planning and determination of the needs of their facilities. In one instance, a facility was unable to run the inpatient services because procurement of the kitchen supplies was delayed as procurement officers at the county headquarters had not involved the facility management team. Facility teams shared experiences of having often developed their plans and corresponding budgets, just to find them completely disregarded in the final determination of the county budget without involving them.

More than half of the health facilities staff interviewed reported difficulties with handling and serving certain types of clients, particularly persons with disability and patients suffering from mental illness. They felt the need to receive periodic trainings to provide them with skills that would enable them appropriately serve such challenging clients. They also felt that the equipment and tools purchased for service provision should take into consideration the unique needs of special interest groups.

Staff also indicated need for protection from some disrespectful, difficult and sometimes violent clients. Staff were also weary of the few but prominent instances of political interference in health service delivery. They felt that politicians displayed a sense of entitlement and felt that their demands, which included the provision of services in a preferential manner to their relatives and friends, must be met regardless of existing protocols and prevailing shortcomings of

the health system. They also felt dejected with political pronouncements on happenings at the hospitals that were not accurately presented. Health staff were clearly terrified of media and felt that the media interacted with the health facilities mainly to discredit them and their work, while not highlighting the difficulties and constraints that they faced in trying to deliver health services.

PATIENT PARTICIPATION IN DECISION-MAKING

Most of the clients interviewed at the health facilities and respondents in various FGDs indicated the lack of involvement of patients regarding their care and the running of health care facilities, by service providers in decision-making. Indeed most indicated that upon explaining their problems and symptoms they would merely be told what they were suffering from and be given a prescription. Many could not contemplate the possibility of asking the health professionals questions on matters of their care. This makes them more of passive recipients of the prescribed treatment.

HEALTH FACILITY CHARTERS

Most health facilities in Bungoma County had 'charters' that focused on a few departments and listed some of the services, indicating how long the service would take and how much it would cost. While those 'charters' provide some limited information, much of it was unclear. For instance the time factor was not explained so a patient could not tell whether it began running from the time they got to the department or from the time they were called in for a service. There was also the assumption that different types of clients would take the same amount of time to receive a specific service e.g. that all x-rays will take 10 minutes whatever the type and regardless of the issues that the patient might have.

CONCLUSION

In essence the findings of this rapid assessment show that public health services in Bungoma County health facilities need to be improved to meet the constitutional threshold with regard to the constitutional values and principles for health service delivery. It is noted that what was evaluated was largely the infrastructure and systems inherited from the central government, and were not unique to Bungoma County. There is hope that the County will review the situation since it is in the infant stages of restructuring and establishing county frameworks and processes for delivery of quality services. The County Government will have to take lead in the operationalization of the Right to Health as provided for in the constitution, and to guide the health facilities to meet the universal standards of Availability, Accessibility, Acceptability and Quality of health facility Service delivery in the County.

RECOMMENDATIONS

1. The County Government of Bungoma needs to develop policies and laws where necessary to guide its team in the delivery of the health function in line with the constitution and any relevant national policies and laws.
2. The County policies and laws must include provisions that guide health workers in public and private health facilities on operations that integrate the values and principles of the constitution and the rights based approach in health service delivery in the county.
3. Each health facility must integrate in its operational frameworks the tools and processes necessary to enhance effective health service provision within the county context.
4. Special interest groups to be catered for in health service delivery must be clearly identified; these include children, women,

and persons with disability, adolescents and youth including teenage mothers, PLHIV, members of ethnic or linguistic minorities among others.

5. The politicization of health in the past resulted in a number of health facilities not being put up where they are needed most, and where they can facilitate equitable access to all, or in line with the WHO recommendation of not more than an average of 5km distance. Bungoma County must scrutinize the distribution of the available health services and corresponding resources and strategize a way of ensuring improved equity.
6. The county needs to quantify its need for Human Resources for Health against the minimum national and international standards, and endeavor to invest in more human resources so as to effectively handle preventive, promotive, curative and rehabilitative aspects of health services.
7. The County should establish and guarantee the minimum service delivery quality standards for all its health facilities in line with the revised service delivery charters. It should then devise adequate modalities of ensuring that the standards are progressively and systematically attained, sustained, improved upon, and monitored on an ongoing basis.
8. The County Government should design a mechanism for dialogue with its health staff and effectively address their concerns over the work environment and conditions, so that senior staff may stay on and serve more effectively.
9. The County Government must urgently invest reasonable funds for facilitating the activities planned under health service delivery. Such investment must include funds for administrative tasks such as supportive supervision and coordination, management training, staff training on rights based approaches as provided for in the charters, counseling and debriefing of staff, as well as for all the service requirements, which have been thus far neglected.
10. The county must review the health facility infrastructure, structures and operations to integrate the needs of special interest groups. This may require investment in renovations to facilitate physical access, employment of sign language interpreters, improvement of services for teenage mothers, youth, children etc.
11. The County Government needs to utilize the intergovernmental mechanism to strategically benefit from the national government technical support for improved health service delivery, and conditional granting for the improvement of service delivery.
12. The mandate of health facility management boards or committees should include the requirement to guide health facilities in the establishment of work cultures that respect the rights of patients, and operations that integrate the values and principles of the Constitution.
13. The County health facilities should review the signage and communication tools to make the health facility environments more receptive and facilitative to clients and patients. This will include training of all health workers on stigma reduction, good interpersonal skills, attitudes change and improvement for better service delivery towards all clients and patients.
14. The service charters should integrate the principles of transparency and accountability, with clarification of all services that are completely free and those that are chargeable, health facility procedures/protocols, cost of services, with clarity on what to pay for, plus where to make the payment and get a receipt

Chapter 1 - Introduction

1.0. BACKGROUND

The Constitution of Kenya 2010 is a transformative and rights based constitution that has secured the right to the highest attainable standards of health and the right to emergency treatment under Article 43. The state is required to ensure that the health and safety of consumers is protected, under Article 46. The Constitution of Kenya has also prescribed values and principles that must guide public service delivery in all state organs, including the rights based approach to service delivery, integrity, leadership and accountability in chapter 6, and values and principles of public service in chapters 12 and 13.

By virtue of Article 2 of the constitution, the health rights listed in International Treaties ratified by Kenya also form part of the laws of Kenya. Among others such treaties include the United Nations Covenant on Economic Social and Cultural Rights (CESCR); the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW); the UN Convention on The Rights of the Child (CRC); the UN 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 the World health Organisation Treaties.

Article 10 states that the values and principles "bind all State organs, State officers, Public officers and all persons whenever any of them makes or implements policy decisions". The national values and principles of governance in 10(2) b include "human dignity, equity, social justice, inclusiveness, democracy and participation of the people, equality, human rights, non-discrimination and protection of the marginalized".

Article 21 requires the state to put in place policy, legislative and other measures including the setting of standards to ensure the progressive realization of the rights in Article 43.

The fourth schedule to the Constitution details the role of each level of government in ensuring the realization of the right to health. It mandates the National Government with the setting of standards, capacity building and national referral health facilities, while the County Governments are mandated with county health services, which include promotion of primary health care and county health facilities and pharmacies, among others.

It is expected that the two levels of government will work in a consultative and cooperative manner with *"government at either level performing its functions, and exercising its powers in a manner that respects the functions and institutional integrity of the government at the other level ".* For instance, the County Government must put in place the necessary structures to enable it deliver county health services of the highest possible standard. For this to be realised, the national government must put in place the national policy and clear standards that will guide counties to deliver on their function. In another instance, the national government cannot arbitrarily develop policy and plans that are not informed by the totality of data on health situations in all the counties. It must therefore work with the County Governments to get the relevant county specific health related data to develop the national health information system. Both levels of government need to review their structures to accord to their assigned functions, and to jointly plan on inter-governmental concerns.

The Bill of Rights has for the first time in the history of Kenya provided for social and economic rights. These are provided in Article 43, and include the rights to water, sanitation, housing and health among others.

Article 189 of the Constitution 2010

This is a report of the project jointly undertaken by the Commission for the Implementation of the Constitution (CIC) and Bungoma County, with the key objective of reviewing the Bungoma County health facility operational frameworks so as to integrate the constitutional values and principles, particularly those in article 10 (which include the rights based approach to service delivery) into health service delivery at the Bungoma County health facilities.

The project evaluated the status of 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 to come up with practical interventions that will ensure the integration of the rights based approaches and other constitutional values and principles into health service delivery. The key deliverables of this project are improved health service delivery charters for Bungoma County that comply with the Constitution of Kenya 2010, alongside this report and its recommendations which are aimed at helping to transform the county's health service delivery culture, going forward.

1.1. STATEMENT OF THE PROBLEM

Prior to August 2010, Kenya did not expressly recognize health as a human right and there was a mismatch between its health sector strategies and their implementation. Government investment in health was meagre, health facilities were lacking - especially in the rural areas of marginalised regions, and demoralization was widespread among health professionals and staff. Not surprisingly, the services rendered frequently fell short of optimal. Clients were perceived as beneficiaries of charity rather than active participants with rights and responsibilities, and the quality of services often failed to measure up to what was guaranteed under the international human rights instruments. From time to time the media highlighted instances of malpractice belying a system failure.

The Constitution of Kenya 2010 has entrenched the values and principles in Article 10, which bind every state organ. The national government and every County Government are therefore under obligation to apply these principles in service delivery. CIC, acting on its facilitative mandate, partnered with Bungoma County to undertake this project as one of the first steps toward the full implementation of the constitution by the county of Bungoma. The integration of right-based approaches into administrative and operational frameworks in the public health facilities is expected to provide a better system for health service delivery within the county.

This project provided an opportunity for the county health facility teams to review its operational frameworks and work cultures, and to clarify key gaps and considerations that must be addressed in order to deliver better services. It is expected that this will in turn contribute to the full realisation of the right to health.

1.2. OBJECTIVES OF THE PROJECT

The overall goal of the baseline assessment was to review the current operational frameworks for service delivery in the Bungoma County health facilities, identify strengths and weaknesses and make recommendations on how the County can integrate the values and principles of the constitution in its health facility services.

1.2.1. Specific objectives

The assessment focused on the following specific objectives:

1. To review the public health facility service charters against the constitutional requirements.
2. To review health service policies, operational frameworks and tools.
3. To assess the service delivery culture at public health facilities
4. To develop the capacities of health service providers in the county health facilities on the rights based approaches to service delivery

1.3. EXPECTED OUTPUTS OF THE PROJECT

The expected outputs of the project were-

1. Revised health service delivery charters.
2. A comprehensive report on the status of service delivery in Bungoma County health facilities.

1.4. SCOPE OF THE STUDY

Whereas this project report and its recommendations are intended to guide health service delivery in all facilities in Bungoma County, the baseline assessment focused only on public health facilities at various levels and drawn from all the sub-counties of Bungoma County namely - Mt. Elgon, Cheptais, Sirisia, Kabuchai, Webuye, Kanduyi, Kimilili, Tongaren and Bumula Sub-Counties. The selection was purposive so as to enable an inclusive and participatory cross sectional survey that utilized a combination of quantitative and qualitative data collection methods to create a representative picture of health service delivery in Bungoma.

Project Area

This project was implemented in Bungoma County, and concurrently, a similar process was taking place in Nyeri and Kitui Counties, constituting three counties that had agreed to serve as pilot sites. This report focuses on Bungoma County.

Bungoma County Profile

Figure 1: Map of Bungoma, Obtained from: Bungoma County Profile

Bungoma County is located in the western part of Kenya, with its western boundary forming part of the Kenya-Uganda border. It covers an area of 3,032 square km, and has an estimated population of 1,790,484 (2012 projection), comprising of 53% females and 48% males, with an average life expectancy of 54 years. It has 325,435 households and the main ethnic communities are Luhya, Sabaot and Teso. It is divided into nine sub-counties – Kanduyi, Bumula, Tongaren, Sirisia, Kabuchai, Kimilili, Webuye East, Webuye West and Mt Elgon. The following table shows the Population distribution of Bungoma County by Sub-County.

Table 1: Population of Bungoma by Sub-County

S/ NO	SUB COUNTY	2014	2017 PROJECTED
1.	Kanduyi	268,884	295,532
2.	Bumula	209,413	230,168
3	Tongaren	219,458	241,208
4	Sirisia	118,893	131,776
5	Kabuchai	165,184	181,555
6	Kimilili	155,479	170,888
7	Webuye East	90,836	99,839
8	Webuye West	178,694	196,404
9	Mt Elgon	201,781	221,780
	TOTAL	**1,608,622**	**1,769,150**

The population is predominantly young, with forty seven per cent (47%) being aged below fifteen years, while the elderly comprise just under four percent (3.8%). Distribution across the County varies, with the most populous sub-county being Kanduyi, followed by Tongaren, while the least populous sub-county is Webuye East, followed by Sirisia.

1.5. PROJECT IMPLEMENTATION METHODOLOGY

The methodology aimed to create a paradigm shift in the manner in which health services are provided and utilized in Bungoma County, by building the capacity of key players within the county system as well as the corresponding

communities served, such that the rights and obligations are understood, upheld, claimed and fulfilled in a mutually collaborative and intentional process. Through a participatory approach that brought on board all key stakeholders and which encouraged local ownership, positive change is anticipated with regards to increasing non-discrimination and diminished violation of human rights as enshrined in the Constitution of Kenya 2010.

The project undertook an extensive document review prior to carrying out a rapid assessment of the prevailing situation, including a review of the existing legal and policy framework, and the auditing of the pre-existing service delivery charters against key Constitution of Kenya 2010 requirements, values and principles. There was also an assessment of the health system operational framework, and the gathering of information on the experiences and views of both the providers and consumers of the Bungoma County public health services. The data collected formed the baseline for the subsequent, recommended interventions.

At the same time the project undertook the capacity building of the County team, comprising of the health system managers and the service providers as well as key stakeholders such as the media and the civil society, in participatory and rights based approaches that emphasize inclusivity and meaningful involvement of the minorities and the marginalized. An inaugural workshop with the national oversight team, plus the Bungoma County leadership and health sector managers obtained data on the Bungoma County profile, built the team's capacity on the rights based approaches, shared out roles and responsibilities of each key player, and finalized the project plan of action. One month later a county capacity building workshop was held in Bungoma town, bringing together the managers and service providers of the county public health sector, selected private health service providers, plus representatives of the civil society, minorities and the media.

Crucial data collection tools were agreed upon, designed and finalized with input from the oversight teams at both national and county levels. The County identified suitable research assistants, selected from each sub-county, who were subsequently trained on relevant qualitative and quantitative data collection methods and familiarized with the relevant tools and ICT gadgets to be used.

The data gathered was collated, analyzed, summarized and then shared back with the County. Through an inclusive and participatory approach, Bungoma County was guided to use those baseline findings to develop revised health service delivery charters that comply with the Constitution of Kenya 2010, particularly the Bill of Rights, as well as relevant articles regarding Leadership and Integrity, Public Finance, and the specified values and principles of Public Service.

Baseline Data Collection and Tools

This section describes the methods and approaches that were used in collecting data for the rapid assessment that was based on the detailed terms of reference, with the respective health sector and health facility management teams playing crucial and active roles.

The rapid baseline assessment utilized purposive sampling of public health facilities to ensure representation of all levels of health care facilities. The primary sampling stratum was the County while the secondary sampling stratum was the Sub County. From each sub-county one hospital, one or two health centres and three to four dispensaries were sampled, proportionate to the population.

Raw data was collected through a cross-sectional survey utilising various methods and tools that combined qualitative and quantitative approaches. Information was captured on a variety of formats and devices including paper, video recordings, and digital voice and data recorders. Android phones were programmed with three of the tools to enable the research assistants to efficiently collect and promptly transmit electronic data from the client exit interviews, the health facility staff interviews and the health facility observation guide.

The following qualitative tools were used:

Client exit questionnaire - was used to interview clients who had already received outpatient services and were exiting the health facility. The research assistants introduced themselves to the respondent, explained the activity and obtained consent before proceeding with the interview. The questionnaire established the client profile, where the client lives, and sought to establish factors affecting access to the facility and relevant aspects of the services received. These included the level of satisfaction with the services received, aspects pertaining to referrals, and client suggestions on areas for improvement.

Structured Questionnaires - were used to interview health facility staff representing all cadres of health care professionals as well as the support workers.

Health facility observation guide - was used to collect data both at the inpatient and the outpatient departments, and involved the use of the senses of sight, smell and hearing to characterize services in the health facility. This also involved photography of relevant items such as service charters and signage. Data was collected against a printed tool and transferred to the android phone on site.

Focus group discussion guide - FGDs were held within the vicinity of the health facility with community members and current patients/ clients identified as consumers of the health services. A few FGDs were held with selected members of the general public.

Key informant interview guides (facility and county level) - Key informant interviews were conducted with the management from the heath facility and representatives from the County Government. The interviews covered the rights based approach and included i) the rights of special interest groups, ii) accessibility, affordability and quality of service provided in the facilities iii) structures of staff development, iv) accessibility of information by staff, special interest groups and clients, v) communication and the sharing of feedback vi) elaboration of opportunities and challenges, and vii) the recommendation for improvement.

Quality Assurance

Several measures were undertaken to ensure that the data collected was of high quality, including a review of methods and tools by the project oversight teams at the county and national level; the objective selection of knowledgeable and experienced research assistants; joint training of the research assistants from all three pilot counties; pre-testing of the tools in similar settings; obtaining the necessary approvals and the considerations; and honouring of key ethical issues. All enumerators were trained in relevant aspects of data collection such as interviewing techniques, accurate recording and transmission of data. The data was further crosschecked by the consultants on a daily basis for validity, consistency, accuracy and completeness.

Data analysis

The quantitative data was processed using the Statistical Package for Social Sciences (SPSS) software, and subjected to appropriate analyses e.g. frequency distributions and measures of central tendency. Qualitative data was thematically analysed. Transcription of the recorded data from key informant interviews and focus group discussions was done and summarized so as to capture the relevant key points. Both quantitative and qualitative data was triangulated to obtain a comprehensive analysis and interpretation of the prevailing situation. This was compared to the desired situation as spelt out in the constitution, and the deviance served as the basis for recommending possible remedial interventions for the Bungoma County Health Services.

Limitation of the baseline assessment

The Bungoma Baseline assessment had a number of limitations as follows:

i. The Health facility classification was in transition and still evolving; a hybrid of different classification nomenclatures existed simultaneously. Among the various official documents shared and in use, some referred to Levels of care, others to Tiers, and yet on the ground the names reflected designations such as Dispensary, Health Centre, and District Hospital. Similarly, out-dated entities such as 'Ministry of Public Health and Sanitation' and 'Ministry of

Medical Services' still featured prominently in official documentation.

ii. The Master Health Facility List simultaneously referred to 'Province', 'County', 'District', 'Sub-County', 'Location' etc. and it appeared that the geographic delineations of administrative units needed to be updated. Correspondingly, on the ground the names of some health facilities differed from those in the MFL for the same GPS. In addition, a given health facility would feature different names in different official documents from various sources, while the altered administrative units at times made it difficult to locate a health facility that might have recently assumed a new name in line with the new administrative unit.

iii. The fairly wide range of potential issues to anticipate in the County, particularly regarding the health related concerns that may be peculiar to some region or location or culture, meant that the tools designed might not have captured all existent issues. Related to this was the difficulty of standardized information on qualitative aspects such as 'complaints' and corresponding redress mechanisms.

iv. Individual biases in the facility observation that relied on personal discretion regarding qualities such as 'cleanliness', etc. presented additional limitations. Also noteworthy were cultural & linguistic biases, especially since English (the project language) is not a first or second language for most respondents, and the research assistants.

i. The availability of key informants and of the desired focus group discussion respondents given the limited time available for the baseline data collection posed some challenge, particularly due to competing priorities for the targeted individuals, among other considerations.

ii. All the same the data collected was of sufficient quality and quantity for the project objectives and provided a reliable picture of the general prevailing situation in a manner to benchmark key aspects of the right to health at the county's public health facilities, while also providing basic considerations that enable Bungoma County to plan for the integration of constitutional values and principles and the rights based approach into its health service delivery.

Chapter 2 - Overview of the Legislative and Policy Frameworks

This project was undertaken against the backdrop of the provisions of the Constitution of Kenya 2010 and various regional and international human rights frameworks, whose key provisions formed the basis of assessing the extent to which Bungoma County is compliant or otherwise.

2.1 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. Article 2 of the Constitution makes the treaties that Kenya has ratified part of the laws of Kenya. 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

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)

environmental conditions, and access to health-related education and information, including on sexual and reproductive health. It also entails the participation of the population 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.

(v) 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.

2.2 REGIONAL FRAMEWORKS

This section 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.

'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

(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. 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

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

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.

2.3 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 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)National Policy

This project was carried out during the transition to a devolved system of government, with health being among the first functions to be devolved. Some of the policies developed after the promulgation of the Constitution 2010 regard health as a human right, and focus on the need for more equitable distribution of the health infrastructure. The new health sector plan endeavours to employ World Health Organization approaches in developing sector strategies, and emphasise the principles of accountability over resource allocation, and of devolved governance

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

in health service delivery. They aim to develop health infrastructure by upgrading and equipping health facilities across the country, including in Bungoma County.

The policies reviewed included the Kenya Vision 2030; Kenya Health (Draft) Policy 2014-2030; Kenya Health Sector Strategic and Investment Plan 2014-2018; Kenya Health Sector Referral Strategy 2014-2018; the Kenya Health Sector Referral Implementation Guidelines 2014; National Guidelines for HIV/STI Programs with Key Populations, 2014; Community Strategy: Taking the Kenya Essential Package of Health (KEPH) to the Community 2006; Community Strategy Implementation Guide 2006; Standards for Peer-Education; and Outreach Programs for Sex Workers 2010.

Some policies, like those for HIV and TB, recognise the need to facilitate health services to key and affected populations including male, female, and transgender persons, commercial sex workers, men who have sex with men, and injecting drug users.

However, the development of a policy to guide service delivery at health care facilities in line with requirements of Article 10 of the constitution, where the rights based approach is promoted for facility service delivery, remains outstanding.

(iii) 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.

(iv) National legislation

There are over one hundred laws applicable to the health sector that need review so as to align them with the Constitution of Kenya 2010 and the devolved health function. At the time of carrying out this project, parliament was in the process of developing the Health Bill, which is anticipated to result in the framework law that will govern the health sector and provide legislative guidance for the realization of the highest attainable standard of health for persons in Kenya, including the fulfilment of reproductive health rights and the guaranteed provision of emergency medical treatment. It is hoped that the resultant law will domesticate the provisions on the right to health that occur in international treaties that Kenya has ratified, in line with Article 2 of the Constitution. Further, the new law is expected to guide the integration of Article 10 values and principles into the provision and delivery of public health services in Kenya.

(v) 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.

(vi) Kenya National Patient's Rights Charter 2013

The Kenya National Patient's Rights Charter, 1st Edition, is a key policy document developed by the Ministry of Health in consultation with civil society. Chapter one describes the rights of the patient - rights of access to healthcare without discrimination, access to information and informed choices, the requirement to treat all patients with respect and dignity, among other considerations. Chapter two describes

the responsibilities of the patient, while chapter three focuses on the client's options for resolving dispute with the health system. While this document illustrates a positive step to reflect the current constitutional dispensation, it falls short of describing the responsibilities and obligations of the health system and of the service providers.

The Kenya National Patients' Rights Charter became operational in October 2013; however, its existence was surprisingly unknown to the health professionals in Bungoma County who alluded not having been involved in its development. It was not one of the policy documents that they were working with. The County officials and the public interviewed were not aware of this charter, as confirmed by the fact that none of them made reference to it, or to any of its contents as at the time of the study.

(vii) Bungoma County Health policies and laws

At the time of carrying out the baseline assessment, the county of Bungoma had not developed any county policy or law to guide its health service delivery. The county health facility teams were, however operating with an arbitrary selection of some of the out-dated policies and guidelines that applied to the health sector and services prior to devolution. They still had and used documents issued by the 'Ministry of Medical Services' and 'Ministry of Public Health and Sanitation'. There was a notable lack of documented key operational frameworks that apply to the health facilities in the present structure.

Of particular concern was the lack of formal written guidance from the county leadership on how the health system should be managed, covering fundamental considerations such as the routine management of health administrative units. Also perturbing was the corresponding lack of resources designated for health administration and management at sub-county level, including funds for essential activities such as supportive supervision of health facilities and of the assigned health staff.

There was not a single circular made available to the assessing team and it would appear that much of the instructions issued were through non-formal means such as SMS and phone conversations. Sub-county health sector managers claimed that there were no formal terms of reference or job descriptions to guide the fulfilment of their responsibilities.

Bungoma County needs to urgently develop its own contextualized health sector policies and laws that will guide the implementation of the constitutional provisions on the right to health and that will enable service delivery to integrate the values and principles in Article 10 and the rights based approach to health service delivery. Correspondingly the county needs to allocate adequate dedicated funds to effectively administer and manage the devolved function of health service provision within its boundaries.

Chapter 3 - Key Findings and Analysis

3.1 INTRODUCTION

This section presents an analysis of the data collected and aims to demonstrate the extent to which constitutional requirements, values and principles are integrated into the Bungoma County Health Services, particularly at health facility level. It amalgamates responses from government and non-state actors, with respondents drawn from the community, the health system (including managers, health professionals and support staff), the county administration, youth, women's groups, community leaders and civil society organizations. The findings are summarised under six elements of the right to health:

i. Awareness
ii. Availability
iii. Accessibility
iv. Acceptability
v. Quality of Health Services, and
vi. Other relevant considerations.

3.2 STUDY DESIGN

The rapid baseline assessment utilized purposive sampling of public health facilities to ensure representation of all levels of health care facilities. The primary sampling stratum was the County, while the secondary sampling stratum was the sub-county. From each sub-county one hospital, one or two health centers and three to four dispensaries were sampled, proportionate to the population.

The design utilized an extensive review of relevant documents, key informant interviews, focused group discussions, client exit interviews, health facility staff interviews and health facility observation, with a focus on establishing the extent to which the public health services comply with the requirements of the Constitution. The findings from a combination of quantitative and qualitative methods were summarized to speak to the basic elements of the right to health - namely Awareness, Availability, Accessibility, Acceptability, Quality of primary health services, and other relevant considerations. The following table summarizes the sampling as undertaken for the baseline rapid assessment.

Table 2: Summary of Sampling for Rapid Baseline Assessment
Table summarizing the sampling for the rapid baseline assessment in Bungoma County

Sub County	Population	% of Health Facilities	County Facility	Sub-county	Health Centers	Dispen-saries	CUs	Total Facilities
Bumula	209,413	13%		1	2	7	42	10
Kabuchai	165,184	10%		1	3	10	24	10 – 14
Kanduyi	268,884	17%	1		2	9	45	10 – 12
Kimilili	155,479	9.7%		1	1	10	17	10 – 12
Mt Elgon	201,781	12.5%		1	2	9	21	11
Sirisia	118,893	7.4%		1	1	7	19	9
Tongaren	219,458	13.6%		1	2	14	26	17
Webuye East	90,836	5.6%		1	1	10	27	12

Sub County	Population	% of Health Facilities	County Facility	Sub-county	Health Centers	Dispen-saries	CUs	Total Facilities
Webuye West	178,694	11%		2	2	12	47	16
Bungoma County Total	1,608,622	100%	1	9	16	88	268	114
Total sampled facilities			1	9	16	25		51
Client Exit Interview			20	135	160	209		524
Facility Staff Interview			3	27	48	42		120
Facility Observa-tion			1	9	16	25		51

Table 3: Health facilities visited in Bungoma by Sub County

	Sub County	No of HF	Percentage	Facility Name
1	Bumula	5	9.8%	Siboti model health centre
				Miluki dispensary
				Bumula subcounty hospital
				Kibuke dispensary
				Kimaeti health centre
2	Kabuchai	6	11.8%	Chemwa Dispensary
				Ngalasia Disp
				Sikusi Dispensary
				Kabuchai HC
				Nalondo HC
3	Kanduyi	7	13.7%	Bukembe dispensary
				Mechimeru
				Ekitale
				Kongoli dispensary
				Ranje dispensary
				Bungoma County Referral
				Mumbule dispensary

	Sub County	No of HF	Percentage	Facility Name
4	Kimilili	5	9.8%	Bituyu dispensary
				Maeni dispensary
				Nasusi dispensary
				Makhonge health centre
				Kimilili district hospital
5	Mt Elgon	6	11.8%	Kamuneru dispensary
				Kaptalelio dispensary
				Sacha health centre
				Mt. Elgon sub county hospital
				Kapkateny dispensary
				Kopsiro health centre
6	Sirisia	5	9.8%	Korosiandet dispensary
				Tamlega
				Lwandanyi dispensary
				Malakisi health center
				Sirisia subcounty hospital
7	Tongaren	5	9.8%	Sango Kabuyefwe
				Sango Naitiri
				Naitiri Sub District Hospital
				Tongareni
				Lungai Dispensary
8	Webuye East	5	9.8%	Lurare Dispensary
				Sinoko Dispensary
				Webuye Health Centre
				Mukhe Dispensary
				Webuye County Hospital
9	Webuye West	7	13.7%	Miendo Dispensary
				Kayaya Dispensary
				Matulo Dispensary
				Milo Health Centre
				Bokoli Sub District Hospital
				Lurare Dispensary

Profile of the Respondents

The Client Exit Interviews involved a total of 524 respondents, of whom 73 per cent were female and 23 per cent were male. In addition, a total of 120 health facility staff were interviewed, including 1 Administration; 2 Allied Health; 10 Clinical Officers; 10 Laboratory Staff; 1 Medical Officer; 55 Nurses/Midwives; 3 Pharmacists; 6 other health professionals; and 32 support staff. Of the respondents, 57.5% were female and 42.5% male; and 75% had worked for three years or longer. A total of 52 health facilities were visited for observation, comprising of ten hospitals, sixteen health centers and twenty-six dispensaries. At one health facility there was no activity as the sole health worker was away for an official workshop, so service provision could not be observed. There were eleven key informant interviews and seven focus group discussions involving a total of 72 respondents/discussants. The overall total number of respondents during the survey was 727.

This assessment was carried out in the context of the transition from a centralized system to a devolved system of governance. Further, the health function was going through the devolution process, and there was a shortage of personnel, both at the national and County Government level who were adequately conversant with the protocols that apply to a devolved health function. The team did not encounter any formal documents to guide the process.

Notable Best Practices in Bungoma County

While in the process of carrying out the rapid assessment of services at various health facilities, the team encountered a number of impressive achievements within the broader Bungoma Health system. There were several outstanding Community Health Units that were actively serving their communities, and that made a positive contribution to the running of the local link health facility. In addition respondents were generally full of praise of the service providers manning the Comprehensive Care Centres located within various hospitals and health centers. These were described as the exemplary health workers within the public health facilities. The youth also expressed appreciation of the highly relevant and more customized reproductive health services that are available only at the very few Youth Friendly Centers that are functioning within the county.

Awareness of the Right to Health

The County Health Department strives to provide Promotive, Preventive, Curative and Rehabilitative Services. On the health system side it was notable that, while much of the health service provision had been devolved to the counties, Bungoma County had not developed any county-specific health policies and regulations. At the time of data collection, there were no county-specific management policies or circulars describing how the health system should be run. Further, the county did not seem to have identified any special interest groups so as to address their concerns.

The existing health service charters had been developed following a top-down approach by the Ministry of Health under the national government prior to devolution. They basically listed the services available at the respective facility, the fees charged, if any, and the amount of time anticipated for each service item. They excluded crucial information on the rights of the client and the responsibilities of the service provider. However, health care workers from various cadres were aware that health is a right, though it was pointed out during the interviews that the Health Policies and Regulations in use in Bungoma were only theoretical and had been developed 'during the Ngilu era' , by virtue of having been borrowed from the National Government as it existed then, before devolution. It was also noted that Bungoma as a county was yet to develop a single health policy, although there existed three draft policies which were yet to be approved. These included: Strategic Health Investment Plan, Facility Improvement Fund Operation and the Implementation of Constitution in Health Sector. There was no policy for nutrition services or for encouraging or supporting professional development of nutritionists. Similarly, there was no document that addressed issues on disability.

[10] *Interview with respondent at Bungoma County on the 11-05-2015*
[11] *Interview with respondent at Bungoma County on 11-05-2015 and at Kimilili sub-county on 12-05-2015*

Feedback from the focus group discussions also indicated that various community members, leaders of women's groups, and public servants were all aware of the Right to Health, even though the reality on the ground in terms of realization of this right was quite different.

Young people who belonged to groups at the few Youth Friendly Service Centers in operation, such as the one at Chwele Sub-District Hospital, were quite enlightened on the right to health and appreciated their responsibility to demand it. Consequently they appeared to have better access to reproductive health services, in stark contrast to the situation for the rest of the vast majority of unaware and unenlightened youth across the county.

Whereas the international and regional treaties and the national policies and laws affirm the right to health, without contextualized county-specific health policies, regulations and frameworks, and the corresponding allocation of funds and resources, this fundamental right may not be realized.

Availability of Primary Health Services

Availability in essence refers to the presence of functional health facilities, with presence of health staff and the availability of basic equipment, essential drugs, consumables and supplies in adequate quantities for the population served. The General Comment No. 14 in Article 12 of ICESCR states: 'functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party'.

Availability also refers to the social determinants of health, such as safe water, adequate sanitation facilities and other health-related buildings, adequately qualified staff receiving domestically competitive salaries, as well as the availability of essential drugs. For health care to be considered "available," facilities and personnel must exist in sufficient quantity and be located within reasonable proximity to all communities, regardless of their geographic location or racial, ethnic, or cultural makeup.

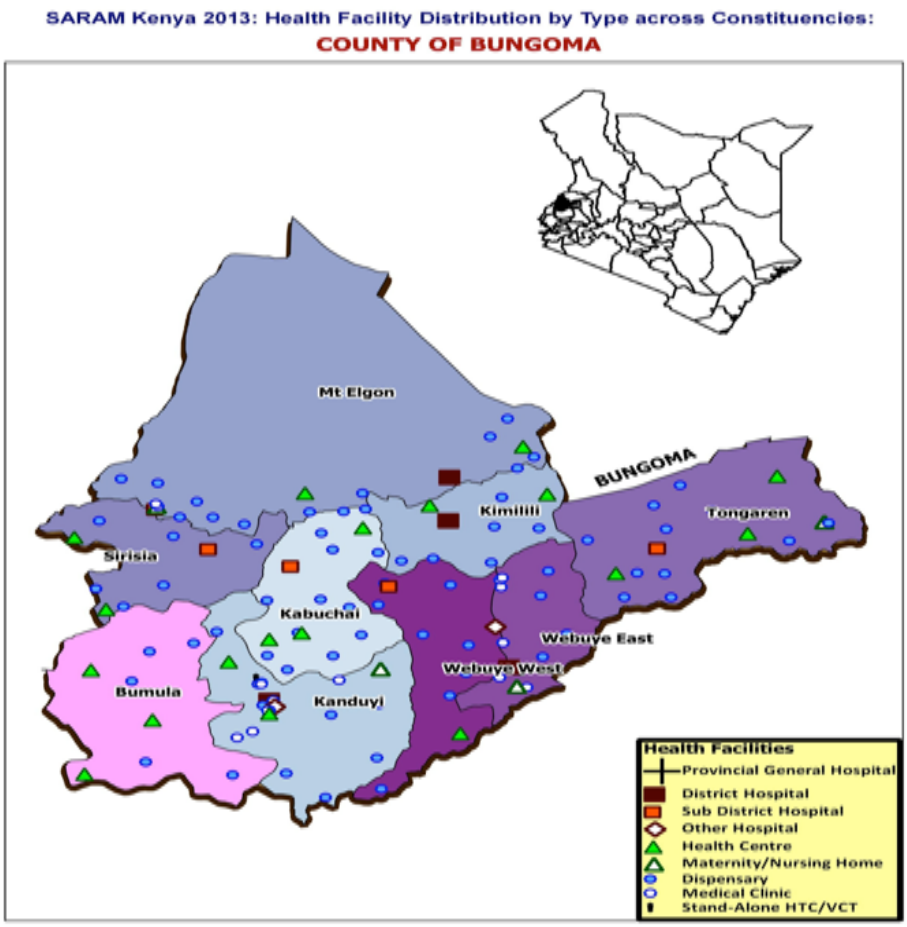
The Bungoma County Master Facility List indicated that there were one hundred and fourteen functional health facilities, including ten hospitals, sixteen health centres and eighty-eight dispensaries. An additional seven health facilities were described as 'pending opening' while another nine were categorized as 'Not Operational'. The following table and map show their distribution.

Table 4: Distribution of Health Facilities in Bungoma by Type & by Sub-County

NO	SUB COUNTY	HOSPITALS	HEALTH CENTRE	DISPENSARIES	TOTAL
1.	Mt. Elgon	1	2	9	12
2.	Cheptais	1	1	10	12
3.	Sirisia	1	1	7	9
4.	Kabuchai	1	3	10	14
5.	Webuye	2	2	12	16
6.	Kanduyi	1	2	9	12
7.	Kimilili	1	1	10	12
8.	Tongaren	1	2	14	17
9.	Bumula	1	2	7	10
	TOTAL	10	16	88	114

[12]General Comment No. 14 (2000): The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights) article 12(a)
"12. The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:
(a) Availability. Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level."

Figure 2: Health Facility Distribution by Type across Constituencies



The county health department workforce consisted of approximately 1,600 employees, made up of consultants, doctors, clinical officers, nurses, lab technologists, pharmacists, accountants, administrators, public health officers, community health extension officers (CHEWS), and support staff. The doctor/population ratio was 1:26,230 while the nurse/population ratio was 1:1854. Both these figures are far short of the WHO recommended standard of three health care workers per 1000, population and the national MOH health facility staffing norms.

Most health facilities were under-resourced in terms of staffing and basic equipment. This means that they were short of essential health professionals, and lacked basic equipment. At the same time most were under-supplied with essential drugs and consumables. Further, disability-specific services were almost entirely unavailable in the public health system, and there was a general lack of rehabilitative services.

Youth friendly services were available only at the 10 hospitals and in an inconsistent manner. From observation, only 7% of health facilities had male condoms stocked in male toilets and only one of the health facilities observed had female condoms stocked in the female toilet. This is reflective of the priority accorded to sexual and reproductive health services.

Of the client exit interview respondents, 75% stated that they had received all of the services recommended for them by the attending health care worker. For the 25% who hadn't received all services recommended, the most common reasons were either the lack of drugs, lack of the required equipment, or non-availability of the health worker.

Table 7 below summarises the availability of staff and equipment in the Bungoma County Health Department, as compared to the minimum requirements based on the Kenya Ministry of Health Norms for the population served. It is noteworthy that the vast majority of the staff were seconded from the national government's Ministry of Health.

Table 5: Availability of Staff in Bungoma County

	Personnel	Numbers	MOH Norms
1.	Doctors	39	70
2.	Nurses	810	1,140
3.	Clinical Officers	134	89
4.	Other Health Professionals	N/A*	99
	TOTAL	983	1,398

** Data was not available during the research.*

Source: Bungoma County Health Official Data

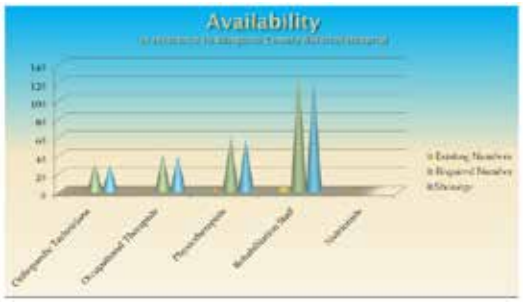
The following is a rundown of the minimum numbers of health professionals by staffing cadre required for a Level 4 Hospital, as recommended by MOH Staffing Norms:

Personnel	MOH Norms
Nurses	178
Specialized COs	12
Radiography Technicians	3
Dental Technicians	3
Laboratory Technologists	3
Physiotherapist	1
Occupational Therapists	1
Orthopedic Technician	1
Social Workers	1
Nutritionists	3
Medical Officers	15
Dentists	2
Pharmacists	2
Support Services Staff	20

While the MOH norms are population-based, there was not a single health facility in the County that met those staffing norms.

In Bungoma County, the optimal availability of health care services is far from being realized, given the high ratios of population to nurse and population to doctor, and the prevalent shortage of essential drugs and supplies. Key informants indicated that the situation was dire, considering that the County had only seven out of a requisite one hundred and thirty rehabilitation staff (2/30 orthopaedic technicians; 3/60 physiotherapists; and 2/40 occupational therapists) that are recommended by the MOH norms, as illustrated in figure 4 below. It was highlighted that there was an acute lack of nutritionists and resources for nutrition services. *"It is difficult to plan for the year as we are only 2; for example it is difficult to plan for community outreach program."*

Figure 3: Availability of a few Overlooked Cadres of Key Staff



These statistics indicate that the County health sector suffers from a severe shortage of health professionals. The World Health Organisation (WHO) recommends a doctor to population ratio of 1:1000 , and a nurse to population ratio of 1:500. The MOH hospital ward staffing norms recommend one nurse for every six patients, yet at the Bungoma County Referral Hospital, for example, reports indicated that a ward would

[13] *Interview with respondent at Bungoma County Referral Hospital on the 11-05-2015 and 12-05-2015*
[14] *Interview with Respondent on the 12-05-2015 at Bungoma County Referral Hospital; See Figure 4*
[15] *Interview with respondent on the 13-05-2015 at Natiri Sub County*
[16] *http://www.who.int/gho/health_workforce/physicians_density/en/ see also http://apps.who.int/gho/data/node.main.A1444 (accessed 27 July, 2015)*
[17] *Interview with Respondent at Kimilili Sub-County on the 12-05-2015*

have only 2 nurses to over seventy admitted patients. The respondent further indicated that at the County Referral Hospital there were only two clinical officers attending to between 300-500 patients daily. The situation reflected a high demand for public health services particularly at the hospitals, against a sub-optimal staffing level. Consequently the few staff available tended to be over-worked and often resorted to practical measures in efforts to attend to all patients. In such situations fulfilment of the sum total of patient rights might not be the foremost priority. During the field interviews it was noted that in some areas, there is such a severe shortage of staff that facilities with only one nurse would actually close when that nurse had to be away for whatever reason.

A key hurdle cited by health managers was the lack of adequate funds for administrative and supervision tasks. Several Sub County Medical Officers of Health interviewed reiterated that they had not received any funds for quarterly support supervision from the Bungoma County Government since the devolution of health services. Their office functions had therefore been grounded, and they had not undertaken any support supervision to health facilities under their jurisdiction because of the lack of funds. Respondents further indicated that the County Health Management Team (CHMT) had not carried out the requisite support supervision during the preceding two years, making it difficult to confidently state what was happening or not happening at the various public health facilities.

Sub-County Health Management Teams (SCHMT) stated that due to the lack funds for supervision, they often resorted to utilising various partner-supported coordination forums to meet with their supervisee staff, even though the main agenda would be different in line with the supporting development partner's priority activity, e.g. the cholera prevention forum that was being held at Bumula during the time of the field data collection.

Staff at the county health facilities expressed concern that the sub-optimal working conditions had remained unaddressed for a long period. Sub-county health managers complained that they had not received terms of reference and that frequently one individual was simultaneously tasked with multiple full-time roles such as Hospital Superintendent and Sub-county MOH, in addition to being the sole doctor at a facility.

Some respondents stated that staff retention has been difficult with personnel leaving for reasons such as salary delays, lack of promotion and unsatisfactory work environment. Such challenges could be attributed to transitional considerations during the devolution of the health function. Some of the doctors were reported to have stayed at internship level (Job Group K) for multiple years after successful completion of internship, having been hired at Job Group K, yet the Public Service Commission minimum for doctors should be job group L. While the Director of Health shared that he had made a proposal for funds for promotion, the timelines for this to be honoured remained unknown. For these and other reasons, staff exhibited low morale.

The shortage of both funds and staff seem to have derailed health service coverage, which is skewed towards the more accessible urban areas. The few doctors available are assigned to the hospitals, which are located at the larger urban centres such as Bungoma and Webuye. The lack of funds has in particular instances been alleviated by partners supporting various health projects in the County such as APHIAplus' which focuses on issues concerning HIV/AIDs, Save the Children which is primarily concerned about maternal health and ACE Africa which caters for the orphans and vulnerable children whose circumstances arise out of the impacts of HIV/AIDS. While such funds boost continuing service provision under the respective program area, they tend to be restricted, for example to training activities. Appreciably such support underscores the importance of participation by non-profit organizations in health care delivery. However, several respondents indicated that the development partners were rigid in their support, and that there was need for development partners to provide funds into a pool that could support all aspects of the overall health needs of the county.

[18] *Interview with Respondent at Kabula Sub-county on the 12-05-2015*
[19] *Interview with Respondent at Kimilili sub-county on the 13-05-2015*

A key informant lamented that development partners with a focus on persons with disability (PWD) were not forthcoming since those available seemed only interested in spheres such as HIV/AIDS and Maternal Health. Despite this, the funds allocated for rehabilitation services by the County Government were a mere 20% of what was required to do a reasonable job. It was stated that the rehabilitation budget in Bungoma only catered for salaries for the very few rehabilitation staff.

It was also shared that there had been no funds from the County for carrying out key nutrition service activities and that the AIEs did not prioritize nutrition.

Compounding the situation was the inadequate medical supplies for the population served and the high numbers of patients visiting the public health facilities. According to the respondents, the supply of non-pharmaceuticals was so erratic that certain groups of patients were forced to buy some of the necessary items from nearby private chemists to enable the health staffs attend to them in the health facilities. These included expectant mothers who were compelled to get their own supplies of items such as gloves, disinfectants, cotton wool and syringes, despite the "free maternity services" proclaimed by the national government.

Several key informants stated that beyond the low budget allocation for purchase of essential drugs and supplies, the County Government allocated a considerably smaller budget towards the purchase of non-pharmaceuticals than the one for pharmaceuticals, creating a serious mismatch between the two. In effect this resulted in a situation whereby, for instance, there might be enough injectable medication, but no syringes and needles with which to administer them; or the gloves and gauzes run out way ahead of the medicines administered during delivery. This feedback indicated that the prevailing procurement process confers higher priority to drugs than it does to the corresponding essential non-pharmaceuticals[20].

"Budget in this area is very low. The budget should be approximately 250 million p.a.; we are only given as much as 50 million. There's not enough for such supplies in the budget.[21]"

Within the nutrition department, it was indicated that the supplies of supplements such as vitamin A were erratic. Similarly the facilities lacked certain crucial equipment, such as weighing scales and height boards for assessing children. This was compounded by the inadequate supply of food to in-patients. Nonetheless, it was stated that vitamin A had been availed to early childhood development centres and a few primary schools.

The Bungoma Public Health system had extremely few specialised doctors. For example, with regards to mental health, Bungoma County did not have even one psychiatrist, implying that patients with mental ailments often were referred to hospitals in other neighbouring counties such as Kakamega and Uasin Gishu Counties. Health Facilities in Bungoma also lacked crucial diagnostic and therapeutic equipment such as renal dialysis machines, CT scan and MRI machines.

In several focus group discussions (FGD) it was stated that while dispensaries exist almost everywhere in Bungoma County, many remain closed for lack of staff. A respondent in Bumula was concerned that the sub-county had no hospital.

"There's no hospital in Bumula. There are only tier 1 & 2 facilities (dispensaries and health centres). Most ailments are referred to Bungoma. There are plans to establish one".

This is against the consideration that Bumula's population totals approximately 216,000 people who were expected to utilise just 10 lower tier health facilities (7 dispensaries, 3 health centres).

[18] Interview with Respondent at Kabula Sub-county on the 12-05-2015
[19] Interview with Respondent at Kimilili sub-county on the 13-05-2015
[20] Interview with respondent conducted on the 12-05-2015 at Kabula.
"Procurement takes seriously issue on drugs and not non-pharmaceuticals e.g. malaria patients taking tabs is easy. Maternal patients delivering use more non pharmaceuticals."
[21] Interview with Respondent at Kabula sub-county on the 13-05-2015
[22] Interview with respondent at Bungoma County on the 11-05-2015
[23] See Figure 5 for a summary of Health Facilities within Bungoma County
[24] Interview with Respondent at Bumula Sub-county on the 13-05-2015a
[25] Interview with respondent at Bungoma county on the 11-05-2015

One respondent stated; *"Lack of a sub-county facility has resulted into acute understaffing – 1 doctor, 6 clinical officers, 50 nurses, 4 lab technicians, 3 pharmaceutical technicians, 15 public health officers."* This is because health professionals, particularly the higher cadres, are allocated by MOH according to the level of the health facility. Unfortunately a dispensary cannot simply be upgraded to a higher tier without addressing the physical infrastructure, among other considerations. Mt. Elgon region was also mentioned as a remote region with few and far-spaced health facilities. Further, its rough terrain and greater insecurity concerns have made it challenging for both health staff and citizens to provide and receive Medical attention as necessary[25].

Figure 4: Availability of Functional Health Facilities in Bungoma County

Public servants and businessmen at a border point revealed that the border market centre lacked piped water, sanitation and a health facility. Also, there were no public means to reach the nearest health facility. During an FGD conducted among youthful respondents, it was noted that services tailored to young people - Youth Friendly Services - were available only at County and Sub County Hospitals, and did not operate reliably throughout the year, since they relied more on the availability of volunteer peer educators. Regarding adolescent sexual and reproductive services it was frequently stated that there were too many unplanned and unwanted pregnancies and consequently many girls and young women resorted to unsafe abortions. Communities wondered why many health facilities put up at considerable cost through the Constituency Development Funds (CDF) remained closed many years later.

Similarly, PWDs lamented that disability specific services were generally unavailable throughout Bungoma County, compelling them to seek assistance elsewhere, often at great personal cost.

Toroso location of Mt. Elgon was reported to have no functional health facility[29]. At Bungoma County Referral Hospital, the lack of basic equipment to support the disabled was highlighted, with no action having been taken despite quarterly reports by Ministry of Medical Services showing the poor state of infrastructure across the County[30].

Figure 5(a): Reason for Choosing this Health Facility

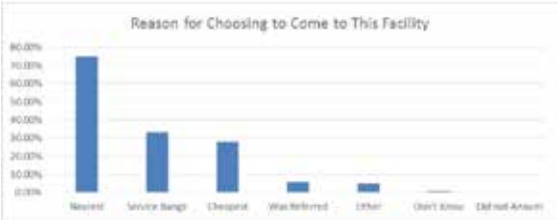
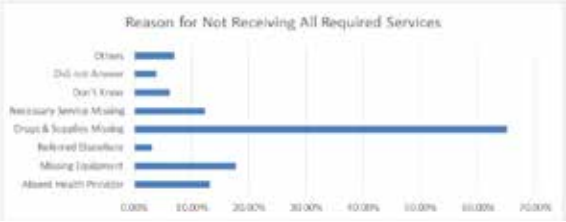


Figure 5(b): Reason for not receiving all Required Health Services



The following table shows the availability of key equipment within the Bungoma County public health system.

[26] *FGD with the youth conducted at Chwele Sub-county on the 14-05-2015*
[28] *Interview with respondent on the 14-05-2015 at Lwakhakha*
[29] *Interview with Respondent at*
[30] *Interview with respondent at Bungoma Referral Hospital on the 12-05-2015 referring to a 3rd Quarter Report 2014/15 by the Ministry of Medical Services*

Table 6: Availability of Basic Essential Equipment within Health Facilities

	Equipment	Quantity
1.	Maternity Beds	488
2.	Maternity wards	14
3.	Maternity Theatres	-
4.	New born Incubator	5
5.	Suction Machine	6
6.	Anaesthetic Machine	5
7.	Operating Tables	5
8.	Ambulance	22
9.	X-ray Machines	5
10.	Ultra sound Machines	1
11.	Facilities with Laboratory Services	6
12.	Haemoglobin meters (Not in use)	-
13.	Binoculars and Microscopes	78
14.	Glucometers	-

Source: Bungoma county health official

The distribution of the available equipment against the total population of the County clearly points to a mismatch and more specifically a shortage in terms of supplies. Similarly, the lack of social inclusion of vulnerable populations in health system planning has deprived them of their right to health and therefore placed them on a very high relative risk for morbidity and premature mortality. This goes even against the interpretation of General Comment No. 14 which has set the standard for every national government to ensure that individuals can make informed decisions about their health and can easily access health care. This basically means that Bungoma County's health sector does not meet the benchmark of availability under the right to health, with a focus on equality and non-discrimination, particularly as it relates to vulnerable populations. The inadequacy of health staff results in insufficient and below par health service provision. Most institutions are often closed during the night thereby making it impossible to attend to emergency cases.

ACCESSIBILITY OF PRIMARY HEALTH SERVICES

Peters et al attempted to define access to health services as 'the timely use of service according to need'. The General comment No. 14 explains this as non-discrimination, physical accessibility, economic accessibility (affordability) and information accessibility. This narrows down to accessibility of health facilities and services for all, without discrimination: health services that are physically accessible and safe to reach for all, including women and girls, and disadvantaged persons (for example persons with disabilities) and groups, affordability for all, particularly for disadvantaged persons and groups, the right to seek, receive and impart health information, whilst respecting the confidentiality of personal integrity and data.

For practical purposes from the perspective of this assessment Accessibility refers to considerations such as the average geographic distance for physical access, physical barriers, the means of transport particularly for persons with disability, costs entailed in accessing services, access to relevant information and inclusive services to all categories of persons in society. A special consideration for the rights based approach is the organizational access, which refers to factors at the health facilities and within the health system such as the location of the services, directional signage, use of uniforms by staff, use of designation & name tags, average waiting time for clients seeking attention, the language of communication and the extent to which a given facility provided an environment that is enabling to the patients among others. Most of the interviewed clients in need of health services cited cost of services and non-financial hurdles as impeding access to health services.

It is important to mention that whereas Bungoma has the highest number of health facilities among the 47 counties, it still fails to meet the WHO standards of distance to nearest Health Facility, especially in the Mt Elgon Sub County region, and the MOH staffing norms. All the same, many respondents described the health facilities as being within reasonable reach, and for 77% of

[31] *Peters DH, Garg A, Bloom G et al. 2008. Poverty and access to health care in developing countries. Annals of the New York Academy of Sciences 1136: 161–71*

[32] *ICESCR Article 12(b)*

exit interview respondents the health Facility was selected as it was the nearest one to home. 79% took less than 30 minutes to reach the facility and for 49% the visit to the Health Facility had involved no transport costs, while 47% had not paid for the services they received.

Transport costs presented a significant financial barrier, especially for those living far from the nearest functional health facility. By virtue of fewer facilities scattered over vast areas, on average, patients in Mt Elgon Sub-County must travel longer distances on poor roads with few vehicles in order to reach the available health facilities. Transport to a further health facility following referral for senior or specialized review thus presents an additional barrier. However, it was notable that some laboratory specimens, especially for PLHIV, were transported regularly by the public health system through the laboratory networking arrangement, and the patient did not have to go elsewhere in person for the required laboratory test to be carried out or to receive the results.

Charges at health facilities presented yet another hurdle. Of the client exit interview respondents 53% had incurred a financial cost while seeking services. This corroborates the complaint from Community Health Workers (level 1 volunteers) who stated: *"Nothing is free - patients pay for malaria treatment, for FP injection; for laboratory tests, for delivering babies and for ambulance services. While the P3 form is free, one must first pay between KES 800/= & 1,500/= for it to be filled"* [33].

Community Health Workers said that often at public health facilities the most important drugs are out of stock and one has to purchase them elsewhere. This echoed a statement from women's groups leaders to the effect that *"the most essential drugs are usually out of stock at public health facilities and so patients have to go to the private chemists where they are expensive: AL (first line anti-malaria drug) costs 100/= for adult and 50/= for child; while medicine for Typhoid costs 1,400/="*

Across Bungoma County there were reports that poor patients get turned away from public health facilities due to lack of money to pay for laboratory tests, drugs and various basic services.

It was said: *""Nothing is free - we have to pay for malaria treatment, for FP injection; for lab tests, for delivery & for ambulance services". "Some health workers make patients pay for medicines which they themselves offer & which clearly are not from the hospital pharmacy, especially for typhoid."* [34]

For PLHIV, non-HIV services are not available without first paying. While the P3 form is supposedly issued free of charge, victims seeking health services are reminded that one must first pay between KES 800/= and 1,500/= for it to be filled by the health worker. Health facility charges impose a greater burden for PWD, most of who are poor. One respondent reported that the health workers use FP commodities to get money from patients despite the fact that they are supposed to be free. Insertion is free, removal costs about KES 500/=. In other cases, even where it was clearly marked NOT FOR SALE on certain drugs, some staff from the institutions still charge for the same with the notion that there had been some costs to procure the same e.g. malaria drugs, Depo, FB[35].

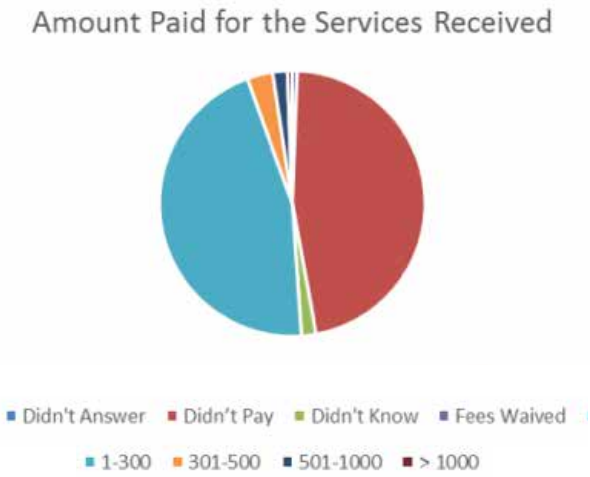
Referrals for health services increase the costs since one must pay for their own transport and the ambulances are expensive. Referrals are made to Bungoma Referral County Hospital which requires the use of ambulances. One respondent indicated that the challenge in such instances includes the shortage of ambulances available, and the fact that in most cases they also sometimes run out of fuel[36].

"There are 2 ambulances used in cases of referrals. There are not so many challenges other than lack of fuel once in a while"

Further, the ambulance charges were considered expensive: "Kibisi-Naitiri 1000/= & Kibisi-Webuye

[33] *Interview with CHW at Naitiri on 12 May 2015*
[34] *FGD at Natiri Sub-County on the 13-05-2015*
[35] *Interview with respondent on the 13-05-2015 at Natiri Sub-County Hospital*
[36] *Interview with Respondent at Bumula on the 12-05-2015*

2000/=, yet by private taxi it is 500/=". It was further shared that "Except for registration, receipts are hardly ever provided for the payments made for services". From the illustrations in figure 7 below, it is clear that while a large number of people receive free services, the majority have to pay some charges in order to be treated.



Only 15% of Client exit interview respondents had an NHIF Card, while 75% of those without NHIF either don't know of it or could not afford it.

Non-financial hurdles included physical access and communication hurdles for persons with disability. Notably, Bungoma County had only two Health Care Workers conversant with sign language. Besides PWD, other special interest groups included: Children, teenage mothers, and stigmatized groups such as PLHIV, Female Sex Workers and Men who have Sex with Men.

With regards to organizational access hurdles, only 51% of the observed health facilities had listed the available services, the days and hours of service, and the corresponding official costs or charges.

Further, only 57% of client exit interview respondents had seen and understood the signage. Notably, the ease of getting around by following the signs was more at smaller health facilities. At the level 4 facilities, comprehension of signs and their use in getting around dropped drastically; in addition, only 56% of health facilities observed had customer care/general enquiry desks. These were mostly in Sirisia (100%), Bungoma South (75%) and Mt Elgon (75%). The worst performing sub county in this respect was Cheptais (0%)

Staff were in official uniforms only at 87% of health facilities observed and, by-and-large, health care staff did not have name-tags, except at few health facilities in Tongaren, Sirisia and Webuye East.

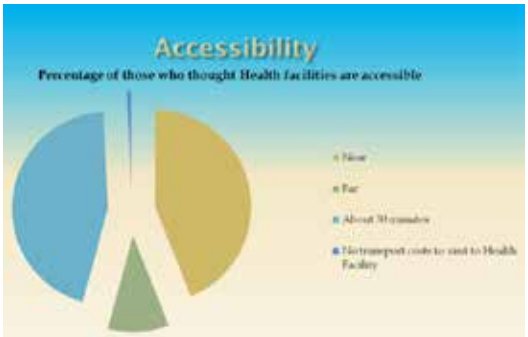
It was indicated that there were regions in the County, more specifically Sirisia, that were historically neglected before devolution, in the former larger constituency, but admittedly things are fairly better in that region. Even so, it was also noted that there is a fair distribution of lower-tier health facilities, but that some sub-counties still lacked a major hospital.

Access to reproductive and sexual health services for young people, which are routinely provided at youth friendly centres in the evening on working days (since that is the most convenient time for them and because the services rely on the availability of volunteer peer educators), was said to be hampered by insecurity on one hand and police harassment on the other.

For most parts, the health system is not accessible to all citizens of Bungoma County. The situation is particularly dire for the vulnerable populations who in some instances are not treated with dignity. Physical accessibility has been hampered in certain instances by the poor management of the ambulance and referral system. This is illustrated by the pie chart in figure below. Furthermore, economic accessibility is hampered in the particular instances where patients are charged for services and drugs that ought to be free, thereby subjecting the vulnerable and poorer households to disproportionate financial strain when compared to the better off households.

[37] *Interview with Respondent at Sirisia- West Bungoma on the 14-05-2015*
[38] *See Figure 8 for a summary of findings on accessibility of Health Facilities*
[39] *Interview with respondent at Bumula Sub-County on the 12-05-2015 "Traditional concepts still persist e.g. home delivery"*

Figure 7: Proportion of Exit Clients who thought Health Facilities were Accessible



Women reported not seeking certain kinds of services, such as reproductive health check-ups and certain family planning methods of choice, because they could not afford to pay for them, which led to small problems becoming serious when left untreated, and an increase in the number of unintended and unplanned pregnancies. In other instances, patients were denied services because they could not pay a deposit fee, resulting in deterioration of health conditions, unassisted deliveries and other serious consequences. Although the National government has implemented a fee exemption for certain services and a general waiver system in public facilities for those who cannot afford the user fees, these systems have failed to protect the vulnerable persons needing reproductive health care services in Bungoma County. The exemption system suffers from inconsistent and ineffective publicity and implementation, so that the people and health care providers do not seem to know about the exemption, or a facility arbitrarily charges for a service that should be free.

Acceptability of Primary Health Services

Acceptability here refers to considerations such as respect for medical ethics; socio-cultural appropriateness of services; ensuring privacy and confidentiality; provision of informed choice on treatment options; freedom of expression and freedom of choice on available options; and a basic respect for human dignity at all times.

The vast majority of client exit interview respondents reported that they had been treated respectfully by most staff at the health facility. There was also systematic review of clients (on a first-come-first-serve basis), except at some health facilities visited in Webuye West & in Mt Elgon sub-counties where it was observed that influential patients or those linked to staff or to politicians and other senior government officials, were accorded priority.

Of the exit interview clients, 90% reported that they had been seen in private when consulting the health worker and this was consistent with what was observed, while 84% had received adequate information/explanation. However, in Sirisia, Bungoma South & Kimilili there were instances whereby staff walked into consultation rooms while the client was being seen. While 57% of the respondents felt that they could ask questions of the service providers, only 47% felt that they could share feedback with the staff regarding the quality of their services.

Not surprisingly, 84% of exit interview respondents were repeat visitors to the health facility. However, at the FGD, People with Disability (PWD) commented that health workers often embarrassed them. For instance the service provider would insist on communicating through the companion of the PWD, or they would express surprise at a lame woman having an STD, etc. PWD also felt that they were often by-passed by the able-bodied clients when seeking health services. It generally takes longer for PWD to be assisted at health facilities. Respondents indicated that some of the disabled were treated with indignity to the extent that they at times left to return home without having received the proper health care they had sought.

Community Health Workers disclosed that persons with mental illness or mental disability were often either ignored at health facilities, or referred verbally to Kakamega CGH[40]. *"Most of the disabled do not have means to get to the hospitals. It's difficult to get them to hospitals. Disabled children in poor families cannot get*

[39] *Interview with respondent at Bumula Sub-County on the 12-05-2015 "Traditional concepts still persist e.g. home delivery"*
[40] *Discussion with CHW on 12tn May 2015 at Naitiri*
[41] *Interview with respondent at Natiri Sub-County on the 13-05-2015*

help to attend hospitals. Although sometimes disabled persons are given priority, the mental ones are generally ignored and usually they are referred to Kakamega or just sent away. Others (mental) are locked indoors at home."[41]

Leaders of women's groups shared that health workers in Mt Elgon Sub-County frequently failed to comply with the established guidelines on proper management of sexual and gender based violence, to the detriment of rape/defilement victims . For example the provision of post-exposure prophylaxis (PEP) following rape was often delayed, thereby reducing its effectiveness.

PLHIV commended staff working in the Comprehensive Care Centres for being efficient; considerate; ethical and professional. In contrast the staff in other departments was described as being discriminatory, unethical, unprofessional and inhumane. Examples included notable impatience when handling PLHIV and frequent instances of a breach of privacy and confidentiality, especially in the laboratory. Additional concerns for PLHIV were that HIV-positive women were blamed and criticized when they got pregnant and that during labour they were often either left on their own or made to buy double the amount of gloves required. PLHIV also faced hurdles and delays when they needed to undergo surgery. For instance women are coerced to accept BTL (surgical sterilization) based on their HIV status. Remarkably, PLHIVs constantly feared that health care workers might reveal their HIV status to others.

Community Health Workers lamented that some professional health workers tended to treat patients according to their socio-economic level – those categorized as being financially better-off were prioritized while the poor would most likely be ignored, particularly at the hospitals. This would seem to contradict the high rates of satisfaction reported by exit client interview, except that the majority of exit interviews were carried out at dispensaries and health centres. Similar sentiments were reflected in the comment by leaders of women's groups who said that at hospitals like Webuye "unless you know someone working there, you can remain unattended from 6am until 6pm". Further *"In some facilities when drugs are few they are only issued to relatives of the health workers"*[67].

It was also shared that some health care workers were not keen to serve NHIF card holders and that they would often ask for 'motivation' from them[67].

Young people reported that they had to be very careful in health facilities because whenever they differed with a health worker, the next time they came for services they would not be welcome and they might even be given some unpleasant treatment. Youth further expressed a general fear of possible breach of confidentiality – especially where the health worker was a relative to the patient. In such situations they felt that they would rather go back home unattended for fear that the relative could disclose one's disease or condition to others.

Figure 8(a): Waiting Time before Being Seen By the Service Provider

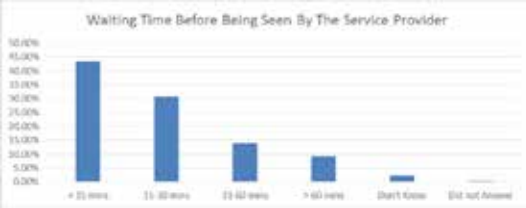


Figure 8(b): Time from Being Seen To Receiving All Services

When asked to appraise acceptability in the health system, key informants reported that the main problems were negative attitudes among some health service providers towards patients perceived to be poor. They lamented the fact that while there exists a disability-friendly guideline at national level, it was yet to be implemented in Bungoma County. As such Bungoma health

[42] *Discussion with leaders of women's groups at Bungoma on 15th May 2015*

facilities were not disability friendly. Community based activities for persons with disabilities could not be carried out for lack of funds, and most health facilities were not properly structured for easy access by persons with physical disability, especially the entrances to the hospital and access to the physiotherapy department.

In several instances it was reported that patients are frequently attended to by unsupervised students. One respondent shared her personal experience during which she was irked by the conduct of one student who could not give injections properly:
"I went to the hospital for a tetanus injection... I was injected several times unsuccessfully by a trainee. I told the trainee to stop playing with me or else I would slap her..." [43]

Another respondent also indicated that the same issue had occurred severally while one nurse injected children:
"A nurse gave injection to one child which led to disability. It was a habit. The kids developed serious swelling. People demonstrated and the nurse was transferred in 2010."

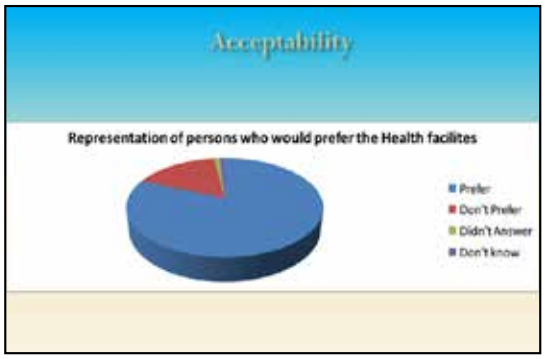
There was also feedback indicating poor inter-personal communication between some service providers and clients. Of concern was that administrators did not regularly communicate with clients on the issues arising. Service providers indicated that with only one doctor for the sub-county it may not be practicable to explain things adequately to each and every patient due to time constraints. Some of the patients stated that certain health staff should be transferred since they would prioritize only those whom they were well acquainted with and would treat the rest without concern. It was repeatedly suggested that some patients who needed constant attention from the health attendants risked being mistreated for reporting any instance of mishandling by the respective health officers. This prompted a few of the patients to seek medical attention in facilities located farther away so as to avoid being subjected to retaliatory harsh treatment.

"I was afraid of attending the hospital again because I feared the nurse I had reported would harm me"[44]

During one FGD it was shared that for expectant mothers seeking facility deliveries, it sometimes became difficult to be attended to and when the assistance was finally provided it was accompanied by verbal and physical abuse. The respondents described being physically harassed during labour. Young mothers were vulnerable to mistreatment where in one particular case of abuse, a woman described being harassed to the extent that she delivered within the hospital compound without any assistance from the nurses. This was after being forced to buy the required gloves, cotton wool and disinfectant. Women also reported that following delivery, they endured long, uncomfortable waits on a hard, wooden bench before being stitched. One respondent described an instance when an expectant mother was being stitched by the medical staff as if "they were stitching a sack".

Notwithstanding the substantial challenges regarding quality of services, the following figure illustrates that the majority of clients served at health facilities in Bungoma County would return in future if they needed medical attention[45].

Figure 9: Proportion of Exit Clients Who Preferred the health facility



Quality of Primary Health Services

Quality as used here refers to factors such as the reputation of the health facility; the effectiveness of treatment; general cleanliness; the availability

[43] *Interview with Respondent at Natiri Sub-County on the 13-05-2015*
[44] *Interview with respondent at Natiri Sub-county on the 13-05-2015*
[45] *See Figure 10 for a summary of findings on those who were satisfied with the Health Services*

of clean water and basic sanitation; the perceptions and understanding of quality (for client and for provider); involvement/participation of the client/patient; steps to enhance feedback and accountability (e.g. suggestion boxes, uniforms, name tags); and the display of the health service charter.

Commendably, there was generally dignified care by virtue of general cleanliness; adequate seating; and the availability of separate toilets for males and females at most health facilities. The baseline rapid assessment found that only 60% of health facilities visited had displayed their service charters – the one described as theoretical and dictated by MOH under a previous regime.

In contrast to feedback from the community, 88% of the exit interview clients felt that they had adequate time with the health service provider and 95% felt welcome at the Health Facility. 84% were satisfied with the services they had received, and 94% said that they would come back in future. A similar proportion (93%) said they would recommend the facility to others and overall, 78% felt that the Health Facility had either a good or average reputation.

Of the health workers, 58% felt that services offered at their health facility were good. However, 73% noted that availability of drugs & supplies needed to be improved; 43% said that laboratory & diagnostic services could be improved; 35% noted a need to increase staffing; and 32% the need to improve inpatient services. Almost all (95%) health workers felt comfortable sharing feedback with management about the services in their facility, in contrast to only 48% of clients who felt that they could share feedback with health facility staff regarding the quality of services received.

In comparison, 88% of patients felt that they had adequate time with the health worker and 57% could ask questions. PLHIVs could not recall ever being invited to be involved in making decisions about their ailments or health conditions. Leaders of women's groups were happy to share that where community units were active, e.g. Kibisi and Mihuu, there was good client participation in decision-making.

Seating for clients seemed adequate, except in Kimilili. 50% of observed health facilities had a suggestion box, especially in Sirisia; Mt Elgon and Kimilili, and 55% of observed health facilities had paved and sheltered walkways for patients. Notably, none of the health facilities visited in Cheptais had sheltered walkways.

Only 33% of observed health facilities had child friendly facilities, and 49% a separate room for HIV care and treatment. Clean drinking water was available for clients in 60% of the health facilities, with the best performance being in Kimilili, Sirisia and Tongaren. General cleanliness and ventilation was good at health facilites,, with some concerns in Webuye West where 33% of health facilities were not adequately clean.

Only 60% of health facilities had separate toilets for male and female clients, with the worst offenders in Webuye West and Webuye East. Most client toilets were locked at facilities visited in Webuye West. Further, client toilets were not as clean in Webuye East, Kabuchai and the facilities that had them open in Webuye West. Also, the health facilities visited in Webuye West, Mt Elgon, Cheptais and Webuye East lacked functional hand washing facilities after vising the toilet. Client toilets were well-ventilated in Tongaren, Bungoma South and Sirisia. Generally there was no easy access to toilets for PWDs and no toilet paper for client's use, while only a few health facilities in Sirisia provided ablution facilities.

Functional hand washing facilities for clients after using the toilet were non-existent in Webuye West, Mt Elgon, Cheptais and Webuye East; however, all health facilities visited in Kimilili had functional hand washing facilities for clients use after visiting the toilet.

There was no service charter, or any announcement to serve as a guide, on the types and costs of services available in 40% of public health facilities.. This was corroborated by a woman who related an experience where she took a rather ill relative to a health facility and was told by staff: *"Uliona huyu yuko serious. Kwa nini ulimleta hapa? Peleka tu Bungoma". (As you can see your patient is in a condition that is too serious for us to manage here. Why did you bother coming here instead of simply*

proceeding straight to Bungoma where such critical conditions are managed?").

Community Health Workers said that often the most important drugs are out of stock. Young people complained that the frequent use of 'trainees' to provide care to patients resulted in sub-standard services. They even claimed that it was common for operations at Webuye County Hospital to be repeated due to errors or sub-standard work in the first place. This was echoed by leaders of women's groups who stated that services are *"often unprofessional - being provided by trainees or even untrained people"*[46].

PLHIVs noted that HIV patients are not offered counselling. Health workers assigned to other departments apart from the Comprehensive Care Centres (CCC) are inhumane, and do not respond to emergencies. They like taking very long breaks, often leaving students in charge of services.

PWD observed that health workers *""come late, take long breaks for tea and lunch, even if there are patients waiting to be served, and they leave early to go home"*

From the service provision side, it was observed that the established service standards in the county include monthly CMEs which are held at Bungoma County Referral Hospital. There was also a reverse referral system for clinical mentorship. Hospital Management Boards had been established, though not much was ascertained regarding their functionality and main areas of focus. It was also pointed out that there were far too many patients, overwhelming the few nurses available. Most of the sub-county hospitals lacked multiple essential disciplines: dental; psychiatric; social work; occupational health; mortuary and medical engineering units, and this adversely impacted upon the quality of services rendered.

However, there was good cross-border collaboration and consultation on matters touching on health and security, with regular meetings taking place between the administration at Malaba border.

People Living with HIV (PLHIVs) described their circumstances at a major hospital as particularly wanting when it came to obtaining counselling and other services not offered at the Comprehensive Care Centre (CCC). The Respondents particularly noted that,

"The staff in the CCCs are very efficient; considerate; ethical and professional. The others are discriminatory, unethical, unprofessional and inhumane. They stigmatize patients from the onset as opposed to CCCs. e.g pregnant mothers are left on their own during delivery."

Figure 10: Client Participation in determining Care and providing Feedback

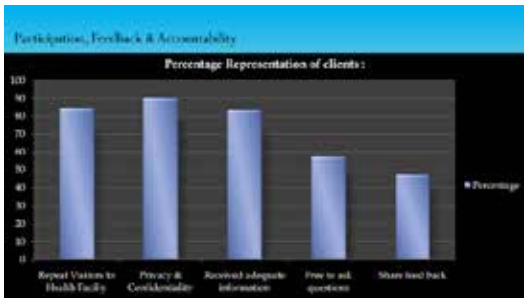


Figure 10(a): Client Satisfaction with various Aspects of Care

Figure 10(b): Client Satisfaction based on Various Considerations

[46] *Discussion on 15th May 2015 with leaders of women's groups at Bungoma*
[47] *Interview with FGD Respondents at a major Hospital on the 13-05-2015*

Other Relevant Considerations

The health service standards were undermined by severe under-staffing; inconsistent availability of essential drugs and supplies; low morale; lack of supervision and the controversial health facility boards. Under-staffing and over-crowding hampered service quality. With regard to monitoring of service quality, it was indicated that the existing appraisal system was not strictly followed. It was also not possible to ensure proper staff supervision due to severe under-staffing and the lack of funds for travel across the county to carry out the supervisory visits. The scarcity of non-pharmaceuticals, which frequently went out of stock, hampered the provision of free maternity services. Reporting tools were also lacking, while some of those available were out-dated. It was shared that doctors cannot be effectively and comfortably supervised by political officials, for professional reasons. Support supervision did not occur either at county or sub-county level due to lack of funds for fuel and allowances, perhaps by virtue of the lack of appreciation of the importance of this function among the politicians who determined the final allocation of funds.

Time was a constraint by virtue of the high demand for services against a severe staff shortage. At the Bungoma County Referral Hospital two clinical officers attend to 300-500 patients daily, while in the wards two nurses look after 70-120 patients at any given time. This becomes a constant challenge especially for people with disability (PWDs).

Several respondents indicated that the County was managing health unprofessionally, alluding that individuals appointed to management lacked the requisite leadership skills and had not been put through proper induction, such that they did not even understand their roles. Management meetings were said to lack focus – for instance, the agenda was at times drafted during the meeting; action points were not implemented and yet nothing was done about this.

3.3 IMPLICATIONS OF THE FINDINGS TO PROVISION OF HEALTH SERVICES

On Availability of Health Services

Predominant type of health facility: Most health facilities in the County (77%) were dispensaries, and some were closed. Ordinarily dispensaries are open only from 8am to 5pm on weekdays, and remain closed throughout weekends and public holidays. What this means is that health services at the nearest health facility for the majority of Bungoma County's residents are available for only 45 hours out of the 168 within the week – translating to 27 per cent of the time. Conversely, for 73 per cent of the time there is practically no availability of basic public health services. As a result most patients are left on their own during those times when the nearest health facility is closed. Further, the lack of services during the weekends and at night results in undue delays for victims of defilement and rape; this continues to have serious consequences.

Staffing: based on MOH staffing norms, the personnel assigned to dispensaries include the cadres of Nurse/Midwife and Clinical Officer. This excludes the potential availability of other health professionals and that of senior clinicians, who are generally allocated to the few higher-level health facilities (health centres and hospitals). Information shared indicated that the Bungoma County public health system had only one physician. Overall, Bungoma remains short of staff, with many dispensaries remaining closed for lack of staff, especially those that had been built through CDF and other efforts.

Types of Services: The types of services at most health facilities were limited to Ante Natal Care, Essential Program of Immunization, treatment of general ailments, and the cleaning & dressing of wounds. Most health facilities still depend on the dispensary kit and its out-dated essential drug list. In addition, many dispensaries did not provide delivery services. Further, none of the dispensaries provided Youth Friendly Services, and very few provided Care & Treatment services for People Living With HIV. None was found to provide basic rehabilitative services.

For the majority of the population, the Bungoma County public health system merely provides some preventive and curative services for a small proportion of the time, with health promotive services and rehabilitative services virtually unavailable. In addition it does not cater for the basic needs of various recognized special interest groups.

The overall findings therefore are that availability of the Public Health System in Bungoma, in terms of the presence of functional health facilities, the presence of health staff and the availability of basic equipment, essential drugs, consumables and supplies in adequate quantities for the population served, falls short of the national policy for the provision of promotive, preventive, curative & rehabilitative health services to all people in Kenya, even as the Constitution requires that these services be of the highest attainable standard that is feasible.

On Accessibility of Health Services

Given that Bungoma County has a poverty index of 53%, the financial hurdles present a barrier that effectively locks out the majority of residents from accessing the available primary health services. In addition there were equity concerns over accessibility, especially for the population residing in Mt. Elgon sub-county, where the average distance to the nearest health facility was much longer and the roads are poor, necessitating greater travel expenses for the area residents when seeking healthcare.

In other instances, it was indicated that insecurity made it challenging to access certain health facilities such as Toloso dispensary which has been built but still not in use. The security team was dispatched to the hospital at the time of interview with the county administration officials doing the field data collection.

The levying of many charges at public health facilities in Bungoma keeps the poor away, yet they form the majority of the population (Bungoma county had a poverty rate of about 53%). It was insinuated that a number of the government health officers had associations with private chemists and private hospitals where some of the patients were referred to. This at times would happens even when the services were available at the public facility where patient had attended.

The failure to list the available services and corresponding official charges at half of the facilities observed opened a loop-hole for unauthorized charges, as reflected in the statement: *"Except for registration, receipts are hardly ever provided for the payments made for services"*

Given the predominance of dispensaries, patient referral is fairly common. However, when a patient is referred for better care, they meet cost of the transport, as well as laboratory and other costs at the referral facility. Such costs present further barriers to the poor.

It is possible that some pilferage is taking place in the health facilities. A senior manager shared that there have been cases where staff stole drugs from health facility stocks. This was corroborated by youth in Naitiri who stated that some staff asked patients to pay for drugs which they then provided from stocks held in their personal bags, especially so for the highly prevalent conditions such as typhoid.

Failure to identify the special interest groups and to address their fundamental needs and concerns has the effect of deterring them from seeking necessary health attention in the public health system, often with serious adverse consequences.

Organizational considerations also have a part to play. Once at a facility, 90% of the patients could easily find their way around, but this was mostly in the dispensaries, which are smaller and fairly straight-forward in design and layout. At the hospitals, the situation was more complicated and many patients required to be directed or shown around the respective departments. This was the case even for the consultants when visiting some of the hospitals, whose signage was noted to be more of jargon – e.g. VIA/VILLI; CSSD; etc.

The presence of staff without uniforms while on duty meant that patients/clients could not

[48] *Interview with respondents at Lwakhakha in Sirisia sub-county on the 14-05-2015*

be certain that they were being attended to by the correct person, with all the attendant implications. In addition, the general lack of designation and name-tags among health facility staff made it difficult for clients, and indeed for the manager responsible for acting, in case there was an issue that elicited a complaint or that needed further follow-up.

Whereas the government policy is for everyone to have NHIF, only 15% of client exit respondents had subscribed to this health insurance. Notably, most of those without it stated that they either did not know about it or they could not afford it.

On Acceptability of Health Services

A positive observation was that the health providers upheld the privacy of patients in the course of treatment - 90% of exit interview respondents had been seen in private when consulting the health worker. However, it generally took longer for PWD to be assisted at health facilities and respondents indicated that some of the disabled were treated with indignity and at times they left to go back home without receiving the proper health care they had sought. *"Most of the disabled do not have means to get to the hospitals. It's difficult to get them to hospitals. Children in poor families cannot get help to attend hospitals. Sometimes disabled persons are given priority. The mental ones are ignored usually they are referred to Kakamega or just sent away. Others (mental) are locked indoors at home."* [49]

The contrast in service experience between Comprehensive Care Centres and other departments, as clearly shared by PLHIV indicates internal inconsistency in the standards of care provided between different departments of the same health facility that the system must urgently address.

There was sub-optimal involvement of clients in their care, rendering them to be more like passive recipients of the prescribed treatment. Overall the findings regarding acceptability of services featured a number of contrasts across the county. In most health facilities the health workers were respectful to clients/patients and generally the care was dignified and provided on a first-come-first serve basis, reducing instances of undue prioritization. However, there were instances of patients having been treated inhumanely with highlights in the media. Notably, there was feedback from community groups that often patients do not complain since they fear it may have backlash or adverse repercussions on them in future

In recent times some incidents of alleged professional malpractice within public health facilities in Bungoma County have featured prominently in the social media and the mass media, and one hospital was even dubbed 'the Sick Hospital' as a result. On their part the health workers claimed that the lack of a formal regular feedback system had causes widespread disquiet and dissatisfaction, and a corresponding plummeting of staff morale.

Inadequate funding for public health facilities could contribute to the emergence of a two-tiered health care system in the county, which discriminates against poor women and other marginalised groups, contravening the constitutional requirements for the right to health.

The patient-doctor relationship is critical to effective health care delivery, which requires trust between the clinician and the patient, a certain level of comfort, and uncompromised communication. The negative experiences by patients at the hands of health staff will have lasting psychological repercussions and are likely to adversely influence their subsequent decisions regarding the use of health services.

Based on the findings, the public health services in Bungoma County did not meet the Acceptability threshold of respect for medical ethics; socio-cultural appropriateness of services; the ensuring of privacy and confidentiality; the provision of informed choice on treatment options; freedom of expression and freedom of choice on available options, and a basic respect for human dignity at all times.

[49] *Interview with respondent at Natiri Sub-County on the 13-05-2015*

On Quality of Services

One in five public health facilities had a below-average reputation and 42% of health facility staff did not feel that services at their facility are good, mostly with regards to lack of drugs and supplies, as well as concerns over the laboratory and diagnostic services. On the flip side, for most health facility clients the quality of health service was synonymous with:

1. Being attended to promptly
2. Being seen by qualified health personnel, and
3. Receiving the required drugs from within the public health system.

These are all considerations well within the ability of the public health system to guarantee. The realization that the majority of patients/clients felt that they could not comfortably share feedback with health facility staff regarding the services received necessitates plenty of work and intentional effort in the area of communication and information sharing with clients. This is an interventional aspect that entails little or no additional cost to the system.

Complaints over the *""frequent use of 'trainees' to provide care to patients, resulting in sub-standard services" and allegations that services are "often unprofessional - being provided by trainees or even untrained people", or that "Health workers are inhumane, and do not respond to emergencies. They like taking very long breaks, often leaving students in charge of services" all point to the need for urgent and in-depth review of how the health system and facilities carry out the essential training of health professionals without which Kenya is unlikely to meet the minimum standards for human resources in health.*

Experiential training either at pre-service attachment or during post-qualification internship is a well-accepted modality for preparing all health professionals worldwide. With regards to the right to health in Bungoma, the emphasis should be on ensuring adequate information sharing, an effort to elicit informed consent from the patients/clients, and clear arrangements regarding proper supervision of the trainee health professionals, so that it does not appear as though work is simply dumped on persons who are not yet fully qualified.

Most public health facilities did not provide ablution facilities, except in some facilities in Sirisia – an example of positive deviance. While most facilities provided gender-designated toilets, health facilities in Webuye West and Webuye East tended not to have separate toilets for males and females. The lack of toilets at some health facilities goes against the government's own public health norms and regulations and needs to be rectified immediately, since this is a fundamental infection prevention requirement according to the Ministry of Health standards.

Public health services in Bungoma do not adequately address the various factors that determine quality of services such as the reputation of the health facility; the effectiveness of treatment; general cleanliness; the availability of clean water and basic sanitation; the perceptions and understanding of quality (for client and for provider); the involvement/participation of the client/patient; steps to enhance feedback and accountability (e.g. suggestion boxes, uniforms, name tags); and the display of the health service charter.

[50] *Brian D. Smedley et. al. (EDS.), Unequal Treatment: Confronting racial and ethnic disparities in health care (2003), at 131.*

Chapter 4 - Conclusion and Recommendations

4.1 CONCLUSION

It is the responsibility of the government to respect the right to health by ensuring laws, policies and operational guidelines that compel it to establish functional primary health care services and that positively reiterate this right to the population. It is also the responsibility of government to protect the right to health by taking measures to prevent third parties such as industries that provide employment or generate income through production and sale of commodities, from endangering the health of the population e.g. through environmental pollution. It is further the responsibility of the government to fulfil the right to health by addressing equity, with regards to ensuring a fair distribution of functional health facilities, equipment, essential supplies and health workforce, and by prioritising the needs of the poor, the vulnerable and those under-served populations.

AAt the time of carrying out this assessment Bungoma County was in the midst of a transition and the County Government was striving to fulfil its responsibilities in the new dispensation where health service provision is one of the devolved functions. Whereas a good number of health facilities were operating and a number of services were being offered, there were some notable findings which need to be highlighted. These are that the Bungoma County Government has to date not legislated the right to health, nor has it developed or enforced corresponding appropriate policies to realize that right to health. This situation facilitates the continuation of some retrogressive health-related policies, programs or practices, including harmful cultural practices such as FGC/FGM. There is urgent need to safeguard health staff against third-party infringements (especially by politicians), and to identify, benchmark and monitor indicators for the right to health. The County Government is yet to comply with minimum core obligations, and must update its operational frameworks to consistently prevent, avoid or halt discrimination, while also taking positive and effective steps towards a progressive and sustained realization of the right to health.

The following recommendations endeavor to present a straightforward way to begin rectifying this undesirable situation in a sustainable manner, which the County Government should consider in order to ensure achievement of the constitutional entitlement of the right to the highest attainable standards of health for the benefits of all its inhabitants.

4.2 RECOMMENDATIONS

On Awareness of the Right to Health

Bungoma County Government must become aware that health is a human right as clearly highlighted in the Constitution. Given that health service provision is a devolved function, it is imperative that Bungoma County Government develops health policies and regulations that are contextualized to Bungoma, while at the same time being compliant with the requirements, values and principles of the Constitution. It must also come up with health system management policies, circulars and administrative guidelines that will enable it begin to realize this fundamental right.

The County leadership needs to appreciate and embrace its role as the principal duty bearer of the right to health and take steps to ensure health service providers respect, uphold, protect and fulfill this right, alongside others. The County Government needs to take steps to ensure that there is a framework for non-discrimination in access to health care, and a deliberately inclusive approach to participation with regards to decision-making in the health system, especially by bringing on board the marginalized and the minorities, and promoting transparency

in decision-making and accountability over resource allocation and management.

It is crucial for everyone, whether service provider or consumer, to appreciate that primary health care is no longer a favour, but an entitlement. In this regard a platform must be forged that brings key stakeholders together, and that encompasses all key cohorts and the identified special interest groups, to work together towards the realization of this right to the highest attainable standards, as envisaged in the Constitution.

On Availability of Primary Health Services

The realization of availability of primary health care services is the responsibility of the County Government and refers to the presence of adequate (in terms of distances and population served) and equitably distributed primary health care facilities that are functional, equipped, staffed and adequately stocked with the essential drugs as far as the epidemiology of disease patterns and health conditions applies to Bungoma County.

Based on the findings of the baseline assessment, there is need to increase the number of health facilities especially in Mt Elgon Sub-County, and more so there is need to ensure that the health facilities are upgraded at least to health centre status so that priority primary health services are available round the clock and all aspects are addressed – preventive, promotive, curative and rehabilitative. The aim of this step would be to increase the availability of primary health services from the present 27-33% of the time towards the 75-85% of the time that would be more in keeping with the constitutional values and principles.

The County should also ensure that in each of the nine sub-counties there is at least one functional level four hospital that is adequately equipped and staffed, including the essential senior clinicians and specialists, and properly stocked with essential drugs and supplies. This will increase access to key higher-level health services and reduce the overwhelming overcrowding at the very few functional level four hospitals that exist.

Correspondingly the County Government must determine the correct numbers of various cadres of health professionals that it requires to fulfill the minimum standards in line with existing MOH staffing norms, as a first and more easily achievable step towards the WHO recommendations that apply more universally.

On Accessibility of Primary Health Services

Besides upgrading the dispensaries to at least health centre status at the majority of sites, and the designation of at least one functional level four hospital in each sub-county, there is need to cascade Youth-friendly services to health centres so as to make sexual and reproductive health services more readily accessible to the predominantly young population in the County. Beyond nominal designation of youth friendly services, it will also be essential to invest in expanding and sustaining the pool of youth peer educators that is crucial for running such services.

The foremost barriers identified to accessing primary health care services arose from the financial costs incurred while seeking health care. Increasing the number of health facilities and ensuring they are more equitably distributed would reduce transport costs. Further, it is important to ensure that whatever is designated as a free service is in fact free – this refers particularly to comprehensive maternal and child health services comprising of all ante-natal, maternity and post-natal services, newborn care, maternal and infant immunization, plus corresponding nutrition and growth monitoring services.

In addition, the County Government must review any charges, and explore then address the reasons why waivers for those too poor to afford what would be considered nominal charges are not working effectively.

Several non-financial barriers to accessing health services also need to be broken down. At the Level Four hospitals, it is important to have a manned customer service desk and clear signage, to ensure clients are not disoriented. In addition health managers must ensure that all staff have and use proper staff uniforms and that

they have and use their name and designation tags at all times while on duty.

Each level four hospital should secure the services of a sign language interpreter, among other interventions to enhance communication with PWD. It is also imperative to consider and address the needs of special interest groups such as young mothers, sex workers and drug users, besides ensuring the incorporation of features such as access ramps for wheel-chair bound clients.

The Bungoma County Government needs to embark on civic education with emphasis on the social determinants of health and to address matters such as access to safe water and to sanitation. It should also explore means of expanding access to social insurance schemes such as NHIF within its communities.

Acceptability of Primary Health Care Services

With reference to the right to health the County public health services need to work towards eliminating discrimination and the upholding of dignity and respect for all the clients. Bungoma County health department needs to invest in customer service orientation for its entire workforce, particularly with regards to engaging special interest groups such as PWD and the youth. There is also need to refresh the staff on proper management of cases of sexual violence or defilement, given the prevalence of HIV within the County, and the technological advances in preventing & mitigating HIV disease.

There is need to involve clients in their care and to encourage and welcome feedback without undue repercussions. The Level Four hospitals should also institute inter-departmental sharing and learning in order to overcome discrepancies such as the contrasting care standards observed by PLHIV who commended staff in the Comprehensive Care Centres (CCCs) for being efficient, considerate, ethical and professional, while in the same breath condemning those in other departments for being unethical, discriminatory, unprofessional and inhumane. Facility supervisors should also insist on the same high standards of service in all their departments and should device ways of ensuring that such standards are achieved and sustained, if not improved upon.

Quality of Primary Health Care Services

The County should enforce basics such as clean toilets that are gender-segregated and that have proper hand washing facilities; adequate seating for clients, especially during the busy market days; sheltered walkways to protect clients from the elements, and safe drinking water while within the health facility.

Most clients interviewed and most FGD respondents equated the quality of health service with prompt attention to patients; treatment by qualified personnel; correct diagnosis of ailments and conditions; and the availability of the required drugs for those conditions. While obviously not exhaustive, these seem considerations that should be guaranteed by the Bungoma Public Health system.

The health department must ensure professionalism among all its cadres of staff. There should be clear job descriptions and the proper institution of a practical system of performance appraisal, perhaps by utilizing a 360 degrees objective-based approach rather than the less effective and more outdated top-down and more subjective system.

Health workers must be punctual and professional. While appreciating that trainees need attachment and experience, this should be achieved under proper supervision and not to the detriment of patients who seek treatment. At no time should patients feel abandoned to students or trainees. Laboratory and diagnostic services must strive to achieve proficiency and to demonstrate professionalism.

Bungoma County Health Department must make use of the available data to determine what to expect in terms of disease patterns and conditions and it must effectively utilize its professionals, especially those more experienced, to determine the required drugs and supplies and also to correctly calculate the quantities and procure them in a timely manner. Its supply chain needs to match the demands and expectations. In essence there is need to overhaul the administration and

management of health services to make it fully professional.

Additional Considerations to enhance the Right to Health

The County health department must ensure its health facility staff has the knowledge and skills to effectively serve PWD, and that they are safeguarded against potential risks posed by some of the clients who may turn violent. In addition, the County must stop politicians from interfering with the running of health services, especially under the guise of providing supervision. Supervision of health professionals must be done in a professional manner by the correct designated and properly qualified officers and according to established professional standards. Any other approach would simply be interference that risks creating undue intimidation and the scaring away of the already scarce medical professionals.

The public health services should integrate adequate and periodic stigma reduction measures and training for all workers in the health system, and to the extent possible the county leadership should appoint a focal person at the County Government to handle issues of PLHIV.

The County should also address the simmering dissatisfaction focused on some of the hospital boards and take steps to ensure that they are elected by the community in compliance with the law so that they are independent. A pertinent question would be: what would it take to uphold the community's choice for membership to health facility boards? A definitive answer would enhance community ownership and support of the established governance and accountability measures.

There is need for special consideration of Mt Elgon sub-county which was found to suffer higher rates of early pregnancy, lower uptake of skilled delivery, and unacceptable rates of fistula, high rates of domestic violence and rampant cases of defilement, alongside other maternal morbidity and mortality. All these point to the need for customizing of services and facilities to this apparently marginalized part of Bungoma County. For instance, among several other pertinent measures, health workers must be capacitated to follow the correct treatment guidelines for rape and defilement victims, especially by ensuring proper and timely administration of PEP (Post Exposure Prophylaxis).

Health workers form the interphase between the service provision and the service consumption sides of the county health system. They bear the responsibility of publicly upholding the state obligations and are simultaneously expected to uphold the professional ethics, and are further required to consistently implement established best practices in order to realize good health outcomes for the patients served. The county leadership needs to be more proactive in facing and addressing the simmering disquiet among its health workforce which was clearly acknowledged on both sides during key informant interviews. Health workers should also be appreciated for their efforts and should be properly oriented on what constitutes a violation of the right to health. They must be actively involved in management decision-making and be supported to uphold professional ethics even as they strive to fulfill the right to health.

Bungoma County's health workers need training to recognize and appropriately respond to the conditions affecting the poor, the vulnerable and the disadvantaged. During the baseline survey the research team encountered a situation where about a dozen children showed up with scabies at a rural health facility that did not have any medication in stock for this simple ailment. They were unfortunately turned away without any treatment.

The state's duty-bearer responsibilities entail immediate, as well as progressive, obligations. Immediate obligations, according to the ICESCR *(CESCR General Comment 14, para 531),* clearly impose a duty on each State to take the necessary steps to ensure that as soon as possible everyone has access to health facilities, goods and services so that they can enjoy the highest attainable standard of physical and mental health. Bungoma County Government would do well to urgently ensure that legislative,

administrative, budgetary, judicial, promotional and other relevant measures are undertaken; that there are special measures to prioritize the health needs of the poor, vulnerable and disadvantaged groups; that there is deliberate and time-bound effort to rectify the existing imbalances and inequity to access to health services within the county. Besides sufficient recognition of the right to health in the County political and legal systems, this will entail a County health policy addressing availability, accessibility, acceptability and quality of health services provided, along with a detailed plan, with costing, for realizing the constitutionally assured right to health.

Progressive realization means that the government must have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of the right to health *(CESCR General Comment 14, para 31)*. Examples of progressive realization would be the development of dynamic county-level measures in pursuit of equitably available and functional primary health facilities that are accessible and offer quality services in a manner that is acceptable, effective and sustainable. Such measures will require targets for specific health outcomes and conditions that also entail a regular review of progress towards the set targets so as to re-define new benchmarks that step-wise lead to the fuller realization of the right to health over time. The County Government and its health department should set and hold itself accountable to targets related to adequate availability of health facilities that operate round the clock, seven days a week. They should ensure greater accessibility by dismantling barriers to access, especially financial barriers to the poor and non-financial barriers to the marginalized, and clear measures to achieve a more equitable distribution of health services and resources.

Other areas that need addressing would be:

- Clear definition or description of Quality Comprehensive Primary Health Care
- Mother and Child Health services that are completely free of charge as stated by government
- Effective measures in pursuit of freedom from violence
- Sexual and Reproductive health information and services, especially for young people
- Adequate interventions in the area of Nutrition and other underlying preconditions to health such as safe water; adequate sanitation and housing; a clean and safe environment
- Ensuring easy access to simple and clear information about health

Two principles underlie each health-related right and must be constantly borne: *State Obligations to ensure non-discrimination in access to health care and to the underlying determinants of health; and State Obligations to ensure participation in decision making —including the design and implementation of policies affecting health, at community, national & international levels.*

At the same time, there is unlikely to be success without addressing the glaring work condition and job satisfaction issues that have already been elicited by other government-led efforts. Suffice to suggest that Bungoma County Health Department can make great bounds by reviving true professionalism among its staff – including through sensitizations on Hippocratic oath principles for clinicians, and Candle-lighting ceremonies for nurses; by setting clear boundaries between the professions while at the same time restoring the multi-disciplinary approach to patient management; and by unifying the common focus of the health professional oversight bodies within the county.

Revision of the Health Service Delivery Charters

In order to ensure everyone is clear on the proper direction in pursuit of the Right to Health, the Bungoma County leadership and the Health Department should review the health facility service delivery charters to ensure strict compliance with the requirements and principles and values of the Constitution. There should be a more comprehensive version as well as a summary version that can be easily read and even be replicated on one wall or banner for public display. In keeping with the spirit of inclusivity, effort should be made to produce the charters in multiple dominant languages, as well as in formats that address those less literate or even the fully illiterate.

Use of technology and emerging forms of Media

During the baseline data collection, frequent mention was made of the use and influence exerted by social media and mass media reports mainly to highlight instances when things did not work right within the health services. Social media and mass media campaigns can also be positively used to share the new direction taken by the County Government and its health services. The health system should forge an alliance with the media to spread good news about what is working right and any positive developments proactively and as a positive engagement strategy. In such a way, the mass media is likely to develop a habit of double-checking the facts with the establishment before releasing them far and wide.

Stakeholder engagement and involvement

There should also be a strategy to engage with the health service consumer in building the capacity of the entire public health system of Bungoma County on the Right to Health as well as on Rights Based Approaches, alongside the development of a plan for monitoring progress on the Right to Health in the County. This would greatly facilitate the process of realizing the right to health.

The Bungoma County Government should collaborate with civil society in monitoring the right to health. Availability could be measured by assessing and tracking of the availability of functional public health facilities. Accessibility could be monitored by tracking discrimination that excludes the poorest, most vulnerable and the marginalized from the primary health services. Accessibility could be monitored through measures of ease of reach of the facilities for the population during various times and seasons, for instance, and the ease of getting about within a health facility for PWD. Affordability of charges for basic services and amenities could also be monitored, as should the ease of access to health-related information and education. Acceptability could be assessed and monitored by tracking conformity with the law and professional ethics, and by agreeing on basic indicators for dignified care and cultural appropriateness of services. Finally the monitoring of quality of public health services should be based on science, the established health service standards (a national government function under the devolved health function) and the regular updating of health workers on various medical best practices.

4.3 A SUMMARY OF THE RECOMMENDATIONS

1. The County Government of Bungoma needs to develop appropriate County policies and laws to guide its team in the delivery of the health function in line with the Constitution and any relevant national policies and laws.
2. The County policies and laws must include provisions that guide health workers in public and private health facilities on operations that integrate the values and principles of the constitution and the rights based approach in health service delivery in the county.
3. Each health facility must integrate in its operational frameworks the tools and processes necessary to enhance effective health service provision within the County context.
4. Special interest groups to be catered for in health service delivery must be clearly identified; these include children, women, and persons with disability, adolescents and youth including teenage mothers, PLHIV, members of ethnic or linguistic minorities among others.
5. The politicization of health in the past resulted in a number of Health Facilities not being put up where they are needed most and where they can facilitate equitable access to all or in line with the WHO recommendation of not more than an average of 5km distance. Bungoma County must scrutinize the distribution of the available health services and corresponding resources and strategize a way of ensuring improved equity.
6. The County needs to quantify its need for Human Resources for Health against the minimum national and international standards, and endeavor to invest in more human resource so as to effectively handle preventive, promotive, curative and rehabilitative aspects.
7. The County should establish and guarantee the minimum service delivery quality

standards for all its health facilities in line with the revised service delivery charters. It should then devise adequate modalities of ensuring that the standards are progressively and systematically attained, sustained, improved upon, and monitored on an ongoing basis.

8. The County Government should design a mechanism for dialogue with its health staff in facilities and effectively address their concerns over the work environment and conditions, so that staff may stay on and serve more effectively.
9. The County Government must urgently invest reasonable funds for facilitating the activities planned under health service delivery. Such investment must include funds for administrative tasks such as supportive supervision and coordination, management training, staff training on rights based approaches as provided for in the charters, counseling and debriefing of staff, as well as for all the service requirements, which have been thus far neglected.
10. The County must review the health facility infrastructure, structures and operations to integrate the needs of special interest groups. This may require investment in renovations to facilitate physical access, employment of sign language interpreters, improvement of services for teenage mothers, youth, children etc.
11. The County Government needs to utilize the intergovernmental mechanism to strategically benefit from the national government technical support for improved health service delivery, and conditional granting for the improvement of service delivery.
12. The mandate of health facility management boards or committees should include the requirement to guide health facilities in the establishment of work cultures that respect the rights of patients and operations that integrate the values and principles of the constitution.
13. The County health facilities should review the facility signage and communication tools to make the health facility environments more receptive and facilitative to clients and patients. This will include training of all health workers on stigma reduction, good interpersonal skills, attitudes change and improvement for better service delivery towards all clients and patients.
14. The service charters should integrate the principles of transparency and accountability, with clarification of all services that are completely free and those that are chargeable, health facility procedures/protocols, costs of services with clarity on what to pay for, plus where to make the payment and get a receipt.

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WHO HRBA brief www.who.int/hhr/news/hrba_info_sheet.pdf (accessed 27 July, 2015)

LEGISLATIVE FRAMEWORK AND POLICIES

INTERNATIONAL

Convention on the Elimination of all forms of Discrimination Against women (CEDAW)
Convention on the Elimination of Racial Discrimination (CERD)
Convention on the Rights of the Child (CRC)
General Comment No. 14 by the Committee of Economic, Social and Cultural Rights: The Right to the Highest Attainable Standard of Health (Art. 12) UN Document E/C.12/2000/4)
International Convention on Economic, Social and Cultural Rights (ICESCR)
International Conference on Population and Development (ICPD) 1994
Universal Declaration of Human Rights (UDHR)

REGIONAL

Africa Charter on Human and People's Rights
African Charter on the Rights and Welfare of the Child
Protocol to the African Charter on Human and People's Rights on the Rights of Women of Africa
Africa Health Strategy: 2007 – 2015- CAMH/MIN/5(III)

NATIONAL

Constitution of Kenya 2010
Public Health Act Cap 242
Public Health Officers (Training Registration and Licensing) Act of 2013
Kenya Health Sector Referral Implementation Guidelines 2014
Kenya health Sector Referral Strategy 2014-2018
Kenya Health Policy 2012-2030
Kenya National Patients' Right Charter 2013
Standards for Peer-Education and Outreach Programs for Sex Workers 2010

Appendices

APPENDIX 1: SUMMARY OF FINDINGS FROM THE HEALTH FACILITY SURVEY IN BUNGOMA COUNTY

Aspect of the Right to Health	Consolidated Findings from the Client Exit Interview; Health Facility Staff Interview & the Health Facility Observation
Awareness of Right to Health	Most health facility clients were unaware of the extent of their right to health. In contrast health workers were generally aware of the right to health, but felt that their rights as staff were not being adequately emphasized. 83% of the health workers did not wear a name & designation tags
Availability of Services	There was a general lack of availability of rehabilitative services
Accessibility – Distance	On average patients in Mt Elgon Sub-County must travel longer distances to reach the available health facilities
Accessibility – Time Spent	79% of patients accessing services at public health facilities live near to the health facility, and 50% walked to the facility for treatment
Accessibility – Costs Incurred	53% of patients treated at public health facilities incurred costs for some or all of the services received
Acceptability – Dignity	95% of patients interviewed reported that they had been treated respectfully by all staff at the health facility. There was also generally dignified care by virtue of general cleanliness; adequate seating; paved & sheltered walkways; availability of drinking water; & 60% of facilities had separate toilets for males & females However, client toilets were locked at facilities visited in Webuye West. Further, client toilets were not clean in Webuye East, Kabuchai & the facilities that had them open in Webuye West. Also, functional hand washing facilities after vising the toilet were lacking at health facilities in Webuye West, Mt Elgon, Cheptais & Webuye East
Acceptability- Effective Treatment	85% of patients were satisfied with the services received at public health facilities & 83% stated that they would come back and would also recommend the health facility to others in need of health services. While 58% of health workers felt that services offered at their health facility were good, 73% noted the need to improve availability of drugs & supplies; 43% said that laboratory & diagnostic services could be improved; 35% noted a need to increase staffing; & 32% the need to improve inpatient services
Acceptability – Non-Discrimination	Except in Webuye West & in Mt Elgon Sub Counties, a first-come, first-serve system applied. Except at a few places in Sirisia, most public health facilities did not provide ablution facilities
Acceptability – Confidentiality	90% of patients reported that they had been seen in private when consulting the health worker & this was consistent with what was observed. However, in Sirisia, Bungoma South & Kimilili there were instances whereby staff walked into consultation rooms while the client was being seen
Participation in Decision-making	88% of patients felt that they had been accorded adequate time by the health worker & 57% could ask questions. However, while 95% of health workers felt comfortable sharing feedback with management about the services in their facility, only 48% of patients felt okay about sharing feedback with the health staff.

APPENDIX 2: SUMMARIZING THE FINDINGS FROM KEY INFORMANT INTERVIEWS IN BUNGOMA COUNTY

Right to Health Aspect	Consolidated Feedback from the Key Informants
County Health Policies/ Regulation	There were no county-specific Health Policies or Regulations developed by Bungoma, & the few in draft form were iterations of national ones
County Health Charter	The existing Service Charters were said to be "theoretical & impractical" and did not align with requirements of the Constitution of Kenya 2010
Needs of Special Interest Groups	Bungoma County was not clear on special interest groups with regards to accessing health services
Equitable Access to Healthcare	While the majority of Bungoma residents lived within five km of a health facility, Mt Elgon Sub-County was an exception & its residents were compelled to travel far to access basic health services.
Barriers to Accessing Healthcare	Additional barriers to accessing basic health services included poverty, staff shortage &, in some places, poor communication infrastructure
Established Service Standards	Severe staff shortage, especially of higher-cadre professionals, prevented Bungoma County from attaining basic standards of health services.
Monitoring of Service Quality	Basic administration and management of the health system in Bungoma was bogged and at times non-functional, so the county did not know what was happening or not happening where, when, how or why.
Disability-Friendly Guidelines	Health facilities in Bungoma were unfriendly to Persons With Disability & essentially the health system was flouting its own disability policy
Information-Sharing with Clients	There was inadequate information sharing both between service providers and their clients, and within the health system itself.
Feedback from Health Workers	Bungoma County's public health system lacked a functional formal feedback mechanism & consequently there was festering dissatisfaction & disquiet among health personnel, with plummeting staff morale.
Collaboration with other Counties	Collaboration with neighboring counties on health matters was minimal and largely informal.
Collaboration with Stakeholders	There were a number of partners in health, most with defined, rather limited & geographically restricted foci on health
Health Funding	Funds that would mitigate health facility operations e.g. FIF, disappeared into a common pool leaving the health facilities utterly frustrated.
County Health Allocation	While the funds allocated to health by the County Government seemed large in comparison to the allocations to other ministries, they were too low to meet even the basic health system needs.
Prioritization of Services	Bungoma County priorities on health were unclear
Prioritization of Facilities	All health facilities in Bungoma were under-resourced & under-supplied
Some Key Challenges	Reservation & disquiet regarding devolution was pervasive among the health professionals
	Health infrastructure was described as "old, dilapidated & inadequate"
	Persistence of basic and fundamental inefficiencies in the health services
	Virtually non-existent rehabilitation services
	Resource allocation was not related to the health service provision needs
	Poor communication between various levels within the health ministry
Key Recommendation to address the Key Challenges	Besides lack of a coherent heath strategic plan, the involvement of key health personnel planning and decision-making was grossly inadequate

APPENDIX 3: SUMMARIZING FINDINGS FROM FOCUS GROUP DISCUSSIONS IN BUNGOMA COUNTY

Aspect of Right to Health	Summary of Feedback from FGD Respondents
Awareness of Right to Health	While youth were generally unaware of the Right to Health, those who belonged to Youth Empowerment Centers were more enlightened PLWH were aware of the Right to Health, but tended to keep silent on rights violation for fear of being stigmatized Public servants were aware of the Right to Health, but said that the reality on the ground was different PWDs were not aware at all of the Right to Health and seemed rather surprised to hear of it Leaders of women's groups were aware of the Right to Health but firmly stated that access to health services remained a dream for most women, regardless Community Health Workers, while aware of the Right to Health, lamented that influential people in the government system kept flouting policies and disregarding what the service charters stated
Availability of Health Services	While dispensaries existed everywhere, but staffing was an issue & many of those put up through CDF remained closed & unutilized many years after being completed Youth friendly services were available only at a few health facilities, e.g. Chwele Sub-County Hospital Lwakhakha border market center lacked a health facility despite its sizeable population and there were no public transport means to the nearest available health facility Disability specific services were unavailable in the public health system
Accessibility in terms of Distance	Most people lived near a health facility & physical distance was not a major concern, except in Mt Elgon Sub-County. However, transport costs to the health was high, especially for PWDs. In addition, hardly any public health facility could claim to be disability friendly
Accessibility in terms of Time	Young people reported that most health facilities were closed in the evening and during the weekends, a fact echoed by public servants at Lwakhakha border market center. Youth also shared that even where YFS were available, access in the evenings was hampered by insecurity on one hand & police harassment on the other. Accessibility in Time spent seeking health services Leaders of women's groups noted that the lack of services at night or over the weekend resulted in undue delays for victims of defilement and rape, often with serious consequences and implications PWD stated that it took them longer to be served than it did for other clients for various reasons e.g. the lack of staff able to use sign language and the fact that most health facilities were not disability friendly. Community Health Workers observation that even in the few places where health services were offered for 24 hours 7 days a week, service quality was much worse at night and during the weekends.
Accessibility in terms of Cost	Community Health Workers noted that patients were routinely turned away from health facilities for lack of money to pay for basic aspects of health service provision - registration, basic laboratory tests & drugs. Youth in Naitiri reported that some staff made patients to pay for drugs which they then proceed to provide from stocks held in their personal bags, especially so for the highly prevalent conditions such as typhoid. PLHW complained that not a single Non-HIV service was available without payment. They observed that health workers would get harsh when one asked for free treatment, even just for AL (the recommended first-line anti-malaria treatment). Staff even charge for some HIV-related test that they called "long ELISA". Community members complained: "Nothing is free - we pay for malaria treatment, for FP injection; for laboratory tests, for delivering babies and for ambulance services. While the P3 form is free, one must first pay between KES 800/= & 1,500/= for it to be filled. Health facility charges imposed a greater burden for PWD. Referrals increased costs since one had to pay for their own transport. Further, the ambulance charges were considered excessively expensive: Kibisi-Naitiri 1000/= & Kibisi-Webuye 2000/=, yet by private taxi it was 500/=. The levying of many charges at health facilities kept the poor away. Surprisingly, it seemed that, except for registration, receipts were hardly ever provided for the vast array of payments.

Aspect of Right to Health	Summary of Feedback from FGD Respondents
Acceptability in terms of Dignity	Young people thought that health officials showed reluctance to assist in situations of emergency, making them seem inhumane and indifferent to the suffering of patients. PLWH stated that their complaints regarding stigmatization were often referred to the community and tended to end up not being addressed. Young people at a youth empowerment center shared the observation that TB patients were either processed hurriedly or they were kept waiting outside and even received instructions through the window, from health workers who openly feared getting infected. PWD said they often got embarrassed by health workers in the facility. A women's group leader shared that in Mt Elgon Sub-County health workers frequently failed to comply with the guidelines on proper management of sexual or gender based violence, to the detriment of rape victims. Community Health Workers were appalled that persons with mental illness or mental disability were often either ignored at health facilities, or referred verbally to Kakamega CGH.
Acceptability in terms of Effective Treatment	Community Health Workers said that often the most important drugs were out of stock Young people complained that the frequent use of 'trainees' to provide care to patients resulted in sub-standard services. They even claimed that it was common for operations at Webuye County Hospital to have to be repeated due to errors or sub-standard work in the first place. Leaders of women's groups stated that services were "often unprofessional - being provided by trainees or even untrained people". They added that in some facilities, when drugs were available they were issued only to relatives of the health staff. PLWH noted that HIV patients were not offered counseling. Health workers were said to be inhumane, and unresponsive to emergencies: "they like taking very long breaks, often leaving students in charge of services". PWD observed that health workers "come late, take long breaks for tea and lunch, even if there are patients waiting to be served, and they leave early to go home"
Acceptability in terms of Non-Discrimination	PWD felt that they were often by-passed at health facilities by the able-bodied clients In addition PLHIVs faced hurdles when they needed to undergo surgery and at times they were coerced to accept BTL (surgical sterilization). Community Health Workers lamented that health workers tended to treat patients according to their socio-economic level – those categorized as being financially better-off were prioritized while the poor would most likely be ignored. Leaders of women's groups said that at hospitals like Webuye "unless you know someone working there, you can remain unattended from 6am until 6pm". In some facilities when drugs were few they were only issued to relatives of the health workers. It was also shared that some health care workers were not keen to serve NHIF card holders and that they would often ask for 'motivation' from them.
Acceptability in terms of Confidentiality	Young people reported that they had to be very careful in health facilities because when they differed with a health worker, the next time they came for services they would not be welcome & they would even be given some unpleasant treatment. Youth further expressed a general lack of confidentiality – especially where the health worker was a relative to the patient. In such situations they felt that it was better to go back home unattended for fear that the relative could disclose one's disease or condition to others. PLWH constantly feared that health care workers might reveal the HIV status of their clients to others
Participation in Decision-making	PLHIVs could not recall ever being invited to be involved in making decisions about their ailments or health conditions. Leaders of women's groups were happy to share that where community units were active and functional, e.g. Kibisi and Mihuu, there was good client participation in decision-making. Community Health Workers stated that in some places health care workers were displeased when CHW were issued RDT kits for malaria diagnosis in the community, along with AL (malaria treatment drugs).

County Government of Bungoma
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, jukumu la wote

County Government of Bungoma

DEPARTMENT OF HEALTH SERVICES