The Right to Health

The County government has a duty to ensure that all its residents enjoy the right to health regardless of their race, religion, colour, age, health status, gender, conscience, belief, culture, disability, marital status and economic and social origin.

A Case Study of Kisumu County
The Right to Health
A Case Study of Kisumu County
Foreword

The right to health is a fundamental human right guaranteed in the Constitution of Kenya. Article 43 (1) (a) of the Constitution provides that every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care. Article 43 (2) also provides that a person shall not be denied emergency medical treatment. Similar provisions are also contained in international and regional human rights instruments, such as the International Covenant on Economic, Social and Cultural Rights and the African Charter on Human and People’s Rights, both of which Kenya has ratified.

To meet its national and international obligations in relation to the right to health, Kenya is under an obligation to take legislative, policy and other measures including setting standards to achieve the progressive realization of the right to health. An important step taken to ensure the progressive realization of the right to health was the devolution of key health services to county governments under the Constitution. County governments now have the primary duty of ensuring that the right to health is realized in all the counties. Some of the main reasons why health was devolved are: to promote access to health services across the country; to address problems of bureaucracy in matters of health service provision; to promote efficiency in the delivery of health services; and to address problems of low quality of health services.

Although there has been progress in the realization of the right to health, significant gaps still exist. There have been concerns about poor services or the total lack of some aspects of health services in the country. The ability of the county governments to ensure the realization of the right to health has also been questioned by some stakeholders, including medical practitioners and members of the public. In particular, the Commission’s Western Regional Office has on various occasions received information and complaints from members of the public on the challenges they face in accessing health services within Kisumu County. Residents have complained that public facilities within the County are underequipped and the infrastructure in place cannot contain
the growing population of residents. Further, there have been complaints that the human resource available is inadequate in comparison to persons seeking medical treatment, thereby limiting the ability of residents to access quality and affordable health care services. The Commission therefore conducted a research to assess the impact of measures that the County Government of Kisumu had taken to enhance the realization of the right to health in Kisumu County.

A number of stakeholders, including members of the public, health workers, hospital administrators and senior County Government officials were interviewed during the data collection process. The research established that the County Government of Kisumu had taken steps to improve service delivery in the health sector, but needed to do more to ensure that its residents fully realize their right to health.

In this report, the Commission makes a number of fundamental recommendations that the state and other stakeholders should consider in working towards ensuring that all residents of Kisumu County enjoy the highest attainable standard of health as envisaged in the Constitution. The Commission hopes that the stakeholders in the health sector in Kisumu will use the findings of this research to inform their programming, policy and legislative developments and other interventions aimed at enhancing the realisation of the right to health in Kisumu County.

Kagwiria Mbogori
Chairperson,

Acknowledgements

The successful conduct of this research saw the involvement of a number of key stakeholders who volunteered information which enabled the Commission to properly assess the status of the realization of the right to health in Kisumu County. The Commission acknowledges the participation of members of the public who reside in Kisumu Central, Kisumu East and Seme sub-counties where the research was carried out. We thank you for your willingness to share your personal experiences and views on matters concerning the standard health services in Kisumu. The Commission also wishes to thank Officer in Charge of Kisumu Main Prison, personnel at the various hospitals in Kisumu visited during the study, and the County Minister for Health, Dr. Elizabeth Ogaja, for their input.

The Commission especially thanks Ms. Elizabeth Odhiambo who was the lead researcher and her entire research team comprising of Penina Sifuna, Elizabeth Agina, Ochanyo Onyango, Mercelynne Okelo, Emmanuel Onyango Odhiambo, Sarah Akinyi, Dora Otieno, James Njau, Ivan Otieno, Faith Nyatichi Ise, Milka Achieng and Boaz Odhiambo Ochieng.

The Commission also acknowledges Dr. Antonina Okuta (Regional Coordinator-KNCHR Western Kenya Regional Office) and Beryl Orao (Human Rights Officer, Western Kenya Regional Office) who steered the entire process, from conceptualization of the research to the preparation of this report. The Commission also acknowledges Dr. Bernard Mogesa who made valuable contribution to the research methodology and the report.

Lastly, the Commission greatly appreciates the financial support received from the Embassy of the Kingdom of the Netherlands.
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<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACHPR</td>
<td>African Charter on Human and Peoples Rights</td>
</tr>
<tr>
<td>AP</td>
<td>Administration Police</td>
</tr>
<tr>
<td>CEDAW</td>
<td>Convention on Elimination of all forms of Discrimination against Women</td>
</tr>
<tr>
<td>CESCR</td>
<td>Committee on Economic, Social and Cultural Rights</td>
</tr>
<tr>
<td>CG</td>
<td>County Government</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil Society Organization</td>
</tr>
<tr>
<td>CGK</td>
<td>County Government of Kisumu</td>
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<tr>
<td>ECT</td>
<td>Electro-conclusive Therapy</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>GDB</td>
<td>Global Development Benchmark</td>
</tr>
<tr>
<td>GVRC</td>
<td>Gender Violence Recovery Centre</td>
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<tr>
<td>ICESCR</td>
<td>International Covenant on Economic, Social and Cultural Rights</td>
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<tr>
<td>JOOTRH</td>
<td>Jaramogi Oginga Odinga Teaching and Referral Hospital</td>
</tr>
<tr>
<td>KEDH</td>
<td>Kisumu East District Hospital</td>
</tr>
<tr>
<td>KEMSA</td>
<td>Kenya Medical Supplies Authority</td>
</tr>
<tr>
<td>KNCHR</td>
<td>Kenya National Commission on Human Rights</td>
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<tr>
<td>NHP</td>
<td>National Health Policy</td>
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<tr>
<td>NHIF</td>
<td>National Health Insurance Fund</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>---------</td>
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</tr>
<tr>
<td>OWG</td>
<td>Open Working Group</td>
</tr>
<tr>
<td>PHO</td>
<td>Public Health Officers</td>
</tr>
<tr>
<td>SDG</td>
<td>Sustainable Development Goals</td>
</tr>
<tr>
<td>UNDHR</td>
<td>Universal Declaration of Human Rights</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
Executive Summary

KNCHR has on various occasions received information and complaints from members of the public on the challenges they face in accessing health services within Kisumu County. The complaints in most cases relate to issues of accessibility, adequacy, availability and quality of health care services within the County. Some of the concerns that have been raised include: lack of adequate and modern medical equipment; understaffing in health facilities; inability of poor members of the public to afford health care services; inadequate physical accessibility; among other concerns.

The negative impacts of the problems plaguing the health sector in Kisumu County range from minor to grave. The unavailability of important medical equipment such as x-ray machines and kidney dialysis machines means that patients who need x-rays or dialysis may have to travel over a long distance before getting the necessary medical attention. Where the cost of health care is prohibitive, the very poor in the society only visit the hospitals when other interventions have failed and the patients are in critical condition. As such, this inhibits early detection and prevention of various diseases, thus increasing preventable deaths. Emergency medical treatment is also greatly impeded due to the requirement that payment be made before a patient is admitted or attended to. The existence of these problems indicate that the County Government of Kisumu has not fully realized the right to health for residents.

Based on the above background KNCHR, in the exercise of its mandate to research on matters affecting human rights, conducted a research to determine the extent to which the right to health had been realized in Kisumu. The research focused on four key issues, namely: accessibility, availability, acceptability and quality of health services. In its assessment, the Commission especially relied on provisions of the Constitution of Kenya, the International Covenant on Economic, Social and Cultural Rights, the African Charter on Human and People’s Rights, and Goal 3 (on health and well-being) of the United Nations Sustainable Development Goals. The research was done in Kisumu Central, Kisumu East and Seme sub-counties in Kisumu County. This report sets out the findings that were made on questions concerning, accessibility, availability, acceptability and quality of health services within Kisumu County. It identifies
existing gaps and makes recommendations on what needs to be done to plug the gaps. The data presented in the report provides evidence-based information to the relevant stakeholders in the health sector and this information can be used to design appropriate interventions. Below are the recommendations made to the County Government of Kisumu:-

To the County Government of Kisumu:

- Enhance accessibility and quality of health services by adequately staffing and equipping health facilities in the County.
- Equip the ward for patients suffering from mental illness (mental ward) with staff, drugs, equipment and facilities to ensure that the treatment of the mentally ill patients is acceptable.
- Invest in infrastructure especially by constructing more medical laboratories, maternity wards, theatres, waiting bays, and staff quarters in the facilities highlighted in this report.
- Employ more medical practitioners in order to improve the staff: patient ratio
- Ensure consistent supply of drugs especially in Kisumu Central Sub-county.
- Prioritize and increase budgetary allocation for health functions.

To the Civil Society Organizations working in the health sector

- Conduct Community outreach programs to improve community attitudes towards mentally ill patients, and reproductive health.

To other stakeholders (Development partners and the National Government)

- Training of staff to respect rights of patients and to give the patients relevant information regarding their diagnosis and treatment.
• Increase funding to County Governments for improvement of the health infrastructure.

To members of the public

• Enhance participation in decision making processes especially in relation to budget making and development of county policies and legislation.
1.1 Background of the study

The report has been prepared by the Kenya National Commission on Human Rights (KNCHR) as part of its statutory mandate under the Kenya National Commission on Human Rights Act No. 14 of 2011 to advise the Government on matters of Human Rights including making legislative and policy reforms.

The genesis of this report was a number of complaints received by the Commission from the members of the public regarding lack of access, cost and quality of health care in Kisumu County. In particular these complaints alleged that:

- Health facilities are ill equipped and the current infrastructure cannot support the growing population
- Human resource is inadequate with low personnel to patient ratio resulting to compromised services
- Health facilities are usually understaffed, ill equipped and offer limited services including emergency services.
- Quality is compromised where necessary machines are unavailable resulting to misdiagnosis
- Health service is unaffordable to the very poor, resulting to patients seeking medical interventions when in critical condition
- The County hospitals not physically accessible to majority of the residents and that residents have to travel far to access health services
1.2 Rationale of the Study

The Constitution of Kenya guarantees each citizen the right to access the highest attainable standard of health including reproductive health care and emergency treatment is unlimited. To achieve this right, the Constitution obliges the state to take legislative, policy and other measures, including setting the necessary standards. Further, the Constitution obliges the State to put in place affirmative action programs to ensure that minorities and marginalized groups have reasonable access to health services. If the State claims that it does not have resources to implement that right, it is the responsibility of the State to show that resources are unavailable and that in allocating resources it shall give priority to ensuring the widest possible enjoyment of that right.

Article 2(6) of the Constitution makes any treaty or convention ratified by Kenya, part of the law. In that regard, at the international level, the International Convention on Economic Social and Cultural Rights (ICESCR) forms part of the law in Kenya. Article 12 of ICESCR provides that States recognize “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”. General Comment 14 of the Committee on Economic Social and Cultural Rights outlines essential elements that have an impact the realization of the right to health as follows:

- a) Availability – healthcare facilities and programs should be available in sufficient quantity.
- b) Accessibility – health facilities should be accessible to all without discrimination, they should be physically accessible, economically affordable and information concerning health ideas should be accessible. Accessibility should include prisoners and minorities.
- c) Acceptability – health facilities and services should be respectful of medical ethics and culturally appropriate.
- d) Quality – health facility, goods and services should be scientifically and medically appropriate, of good quality, skilled medical personnel.

---

1 Article 43 1 (a) and 2
2 Article 21 (2)
3 Article 43 1 (a), 43(2) and 56 of the Constitution of Kenya (2010)
6 ICESCR Committee General comment No 14 paragraph 1, 34
and unexpired drugs and medical equipment.

The Sustainable Development Goals and in particular goal number 3 prioritizes certain areas of health including communicable, non-communicable and environmental diseases; reproductive, maternal child health; universal health coverage; safe, effective, quality and affordable medicines and vaccinations.\textsuperscript{7}

At the regional level, the African Charter on Human and People’s Rights, 1981 (ACHPR) states that every individual shall have the right to enjoy the best attainable state of physical and mental health.\textsuperscript{8}

The Constitution of Kenya ushered in the County system of Government, and some functions like health have now been devolved to the County together with a budget allocation for that function. This includes primary health care, health facilities, pharmacies, funeral parlours, emergency services, veterinary services, waste disposal and licensing of hotels.\textsuperscript{9}

The County Governments have set up County Executive Committee in-charge of Health to lead in implementing this duty.

The Kenya National Commission on Human Rights has a mandate to ensure that every citizen of Kenya enjoys the rights enshrined in the Constitution and it is for this purpose that the KNCHR has commissioned the audit of this right by the County Governments. This study focuses particularly on the County of Kisumu.

\subsection*{1.3 Objectives of the Study}

The KNCHR will assess the extent to which the County Government of Kisumu is enhancing the attainment of universal health coverage, including access to essential quality health care services and vaccines for all including reduction of maternal mortality, child mortality, AIDS epidemic, Tuberculosis, malaria, tropical diseases, waterborne diseases and other communicable diseases.

\begin{footnotesize}
\begin{itemize}
  \item \textsuperscript{7}Sustainable Development Goals, No 3
  \item \textsuperscript{8}African Charter on Human and Peoples Rights, Article 16(1)
  \item \textsuperscript{9}Article 203(2) and Fourth Schedule, Part II of the Constitution of Kenya
\end{itemize}
\end{footnotesize}
The research seeks to establish impediments to the right to health within Kisumu County and the data collected will form evidence based information to the relevant stakeholders in the health sector and is to be used as an advocacy tool in promoting access to health care for all.

1.4 Methodology of the Study

This research was conducted primarily through desk review of relevant literature and field interviews with relevant stakeholders. Desk research was undertaken to understand existing literature on right to health. Books, journals, articles and reports were reviewed. Government, regional and international documents legal instruments relevant to the research topic were used. Field research was undertaken in order to collect primary data that would be used to assess the status of provision services in Kisumu County. Data was collected in two ways:

a) Individual interviews using structured questionnaires: the research assistants asked the respondents questions and transcribed the answers. This was necessary due to different levels of literacy of the respondents as well as limitations of time. This information was then analyzed qualitatively. The respondents included 130 members of the public [randomly sourced from within the premise of the health facility, market places, bus stages and residences], 24 Hospital administrators and 25 Health Workers [doctors, clinical officers and nurses] all found within the health facilities. In addition, an interview was held with the Minister for Health in the County Government of Kisumu and the information analysed.

b) Focus Group Discussions/Interviews: Focus Group Discussions were held in three health facilities namely the Prison, Mental Health Unit and HIV/Aids and Maternal/Child Care Units. The discussions were held with the administrators of these units and the information transcribed and analysed.
1.5 Sample size

The data was collected from three out of the seven sub counties of Kisumu County, one urban and two rural to give a comprehensive survey of the state of health within the County.

Those who participated in the survey were 130 members of the public, 24 administrators of health institutions, 25 health care workers namely doctors, clinical officers or nurses (Table 1 below shows the health facilities visited and the number of respondents interviewed.)

<table>
<thead>
<tr>
<th>Sub County</th>
<th>Health Facility</th>
<th>No of Public</th>
<th>No. of Administrators</th>
<th>No. of Doctors, Clinical Officers, Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seme</td>
<td>Kombewa County Hospital</td>
<td>12</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>BodiKolunye Dispensary</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Nduru Kadero Dispensary</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Arito Langi Dispensary</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Onyinjo Dispensary</td>
<td>6</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Ratta Dispensary</td>
<td>6</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Rodi Dispensary</td>
<td>6</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Manywanda Sub County Hospital</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Miranga Sub county Hospital</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Kuoyo Kaila dispensary</td>
<td>5</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Oserwe</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Rongo Health Centre</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Asat Dispensary</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Kisumu Health Facility</td>
<td>Visits</td>
<td>Respondents</td>
<td>Interviewed</td>
<td></td>
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<tr>
<td>------------------------</td>
<td>--------</td>
<td>-------------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>Chiga dispensary</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Orongo Health Centre</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Nyalunya sub county hospital</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Simba Opepo Dispensary(Obwolo)</td>
<td>4</td>
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<td></td>
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<tr>
<td>Gita sub county hospital</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td></td>
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<tr>
<td>Kotunga dispensary</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Rabuor District Hospital</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Jaramogi Oginga Odinga Teaching and Referral Hospital</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Lumumba Sub County Hospital</td>
<td>9</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Kisumu East District Hospital</td>
<td>5</td>
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<td>1</td>
<td></td>
</tr>
<tr>
<td>AP line dispensary</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Victoria Annex</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Nyalanda Health Centre</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Joel Omino Dispensary</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Busembe dispensary</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Pandi Dispensary</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Dunga Dispensary</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Railway dispensary</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL** | **130** | **24** | **25**

Table 1. Health facilities visited and respondents interviewed
Focus group interviews were conducted with administrators of facilities namely the ward for patients suffering from mental illness (mental ward): prison health facility, HIV/Aids clinic and Maternal and child care clinic at JOOTRH.

An interview was also conducted with the Minister for Health, Dr. Elizabeth Ogaja.¹⁰

1.6 Research Team

The research was led by a Consultant, Mrs. Elizabeth Odhiambo, and a team of twelve research assistants.

1.7 Literature Review

**UNCESCR General Comment 14, the Right to Highest Attainable Standards of Health (Article 12) General Comment No. 14 (11/08/00) (E/C.12/200/4).** Paragraph 1 states that health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The realization of the right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programmes developed by the World Health Organisation (WHO), or the adoption of specific legal instruments.

**UN Office of the High Commissioner for Human Rights, CESCR General Comment No 3: The nature of States parties obligations (1 12/14/1990).** Paragraph 18 observes that countries with fewer resources are allowed to progressively realize the right to health, however it advocates for immediate implementation on non discrimination measures on health. It notes that in times of severe resource constraints vulnerable members of society must be protected by adoption of relatively low cost targeted programmes, legislative avenues and dissemination of information.

¹⁰Interview with Dr. Elizabeth Ogaja, Minister for Health, County Government of Kisumu on 21st March 2017.

The paper discusses the right to health is one of a range of socio-economic rights for which states are obligated to fulfill under international law. However, the politics of fights has meant that socio-economic rights are rarely given the same status as liberal freedoms associated with civil and political rights. There is therefore need for a framework to ensure that socio-economic rights are fulfilled rather than ignored.


Anja R, Benjamin M. 2010. “Right Based Approach to Public Health” The paper discusses the concept of healthcare as a public good and human right grounded on in social justice as opposed to a commodity to be purchased in the market. It notes that human rights are universal, inalienable and indivisible with each claim of the right holder implicating correlative duties on the government. It further advocates for a move away from the notions of non obligatory or progressive implementation of right to health towards a more formal obligation which provides for a legal and analytical framework for evaluating the right to health.


The paper discusses the feasibility of attainment of the right to health. It notes that a states difficult financial situation cannot absolve it or justify it from not realizing the necessary standard on the right to health. It further notes that the factors to be taken into account are the availability of resources at that time and the development context.

The paper evaluates the two tier system of government in Kenya and the roles they play in attainment of the right to health. It notes that under the devolved system the national government and the county government are interdependent and their relations are by way of consultation and cooperation. With respect to health, the national government is expected to provide leadership in health policy development, manage national referral hospital and provide technical assistance to counties. The county governments are responsible for county health services, regulating pharmacies, providing ambulances and promotion of primary healthcare.

**Limburg Principles on the Implementation of the International Covenant on Economic and Social Rights.**

The committee evaluated the scope of obligation of state parties to International Covenant on Economic and Social Rights. Paragraph 2 observes that the obligation to achieve progressively the full realization of rights, the right to health included, requires state parties to move as expeditiously as possible towards the realization of rights. It further notes that obligations of progressive realization exists independently of increase in resources, it requires the effective use of available resources. The signatory state must not only intend to provide healthcare to all its citizens but it must also move immediately to do so even if it has limited resources.

### 1.8 Limitation of the Study

This study was carried out at a period when the doctors in Kenya had just come back from a national strike and were just reporting back to work. Therefore, few doctors were interviewed as they were dealing with the huge demand for their services. Although the study stayed clear from questions relating to the strike, some of the respondents appeared to fault the County Government on the right to health based on that strike. In addition, the head of the TB unit was not available during the Focus Group Discussion at the JOOTRH and therefore the data contained on TB management was only obtained from respondents who participated in the focus group discussions.
2 CONCEPTUAL AND NORMATIVE CONTEXT ON THE RIGHT TO HEALTH

2.1 Legislative and Policy Framework

Right to health is one of the most important right for human condition without which the exercise of other rights is indispensible. This has been well documented by the World Health Organization which expressed that ‘without health, other rights have little meaning.’ The realization of the right to health can be made through complementary ways such as development of health policies, implementation of health programs developed by the World Health Organization (WHO) or adoption of specific legal instruments.

2.1.1 Legal Framework

International Instruments

The United Nations Charter (1945) only attempts to provide for solutions to health problems without necessarily declaring the right to health for individuals. Article 55 provides for promotion of rights (including health) and development as a way of ensuring stability and wellbeing of the members. The members are thus expected to promote; higher standards of living, full employment and conditions of economic and social progress and development, solutions of international economic, social, health and related problems and international cultural and educational cooperation and universal respect for, and observance of human rights and fundamental freedoms for all without distinction as to race, sex, language or religion.

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12 ICESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)
Article 25 of the Universal Declaration of Human Rights (1948) states that: “every person has a right to a standard of living adequate for the health and well-being of himself and his family including food, clothing, housing, medical care, social services and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.” It further provides that “motherhood are entitled to special care and assistance and that all children whether born in or out of wedlock shall enjoy the same social protection.”

Article 12 of the International Covenant on Economic, Social and Cultural Rights (1976) mandates the state parties to recognize the right to the highest attainable standard of physical and mental health. It further espouses the required steps to ensure the full realization of the right to health. They include; “the reduction of stillbirth rate and of infant mortality and for the healthy development of the child, the improvement of all aspects of environmental and industrial hygiene, the prevention of treatment and control of epidemic, endemic, occupational and other diseases and the creation of conditions which would ensure all medical service and medical attention in the event of sickness.”

The Convention on the Elimination of all forms of Discrimination Against Women (1979) expressly addresses the realization of right to health to women. Article 12 underscores the fact that maternity and reproduction are twin requirements to right to health. It mandates the state parties to take appropriate measures to: ‘eliminate discrimination against women in the field of healthcare and to ensure equality in the access to health services including family planning.’ Further, the states are required to provide women with ‘appropriate services in connection with pregnancy, confinement and post-natal period, provision of adequate nutrition during pregnancy and lactation and granting free services where necessary.’

Article 14 addresses the challenges faced by women in rural areas by requiring the state parties to ensure women are able to ‘access adequate health care facilities including information and counseling and services in family planning.’ It further recognizes sanitation and water supply as an essential to adequate living standard.
Regional Instruments

Article 16 of the African Charter on Human and Peoples' Rights (Banjul Charter) (1981) underscores Article 12 of the ICESCR by providing that “every individual have the right to the best attainable state of physical and mental health.” The state parties are further expected 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 14 of the Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa (2003) recognizes that right to health of women encompasses sexual and reproduction health. The state parties are mandated to ensure that the right to health of women is respected and promoted by availing women with the right: “to control their fertility, to decide whether to have children and the number of children and spacing of children, to choose any method of contraception and to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS, to have a family planning education."

The state parties also have a duty to: “provide adequate, affordable and accessible health services including information, education and communication programmes to women especially those in rural areas, to establish and strengthen prenatal delivery and post natal health and nutritional services for women during pregnancy and while they are breast feeding, and to protect the 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 of the foetus.”

Domestic Legislation

Article 43 of the Constitution of Kenya (2010) entitles the citizens to right to health which encompasses the following: “the highest standard of healthcare services including reproductive healthcare, accessible and adequate housing and reasonable standard of sanitation, free from hunger and adequate food of acceptable quality, social security and education.” Accessibility to emergency
treatment is unlimited. The state is mandated to provide support to those who are unable to support themselves and their dependants a means of realization of social security.

### 2.2 Policies

#### 2.2.1 International Policies

The International Health Regulations (2005), or IHR (2005) represents a binding international legal agreement involving 196 countries across the globe, including all the Member States of WHO. Their aim is to help the international community prevent and respond to acute public health risks that have the potential to cross borders and threaten people worldwide. The purpose and scope of the IHR (2005) is to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.

There is also the Integrated Disease Surveillance and Response (IDSR) which is a strategy of the World Health Organization Regional Office for Africa for improving epidemiologic surveillance and response in the African region. Surveillance is the ongoing systematic collection, analysis, and interpretation of health data. It includes the timely dissemination and use of information for public health action.

In the year 2012, the United Nations set out a mandate to establish an Open Working Group on post 2015 Agenda. The Working group came up with 17 Sustainable Development Goals which were adopted by the United Nations General Assembly in the year 2015 as the Global Development Benchmark up to the year 2030.

Pursuant to this, Kenya domesticated thirteen Sustainable Development Goals relevant to development. Goal number three specifically provides for achievement of healthy lives and promotion of wellbeing for all at all ages. The goal is expressly linked with Social pillar under Kenya Vision 2030 all of which must be realized before the year 2030.¹⁴

¹⁴The Kenya Vision 2030 is the national long-term development policy that aims to transform Kenya into a newly industrializing,
The goal is derived from Article 26 of the 2030 Agenda for Sustainable Development goals. It call for: “promotion of physical and mental health and wellbeing and to extend life expectancy for all, the need to access to quality health, reduction of newborn child and maternal mortality by ending preventable deaths, ensuring access to sexual and reproductive health-care services including for family planning, information and education, accelerate the progress made in fighting malaria, HIV/AIDS, tuberculosis, hepatitis, Ebola and other communicable diseases and epidemics including by addressing growing anti-microbial resistance and the problem of unattended disease affecting developing countries, and prevention and treatment of non-communicable diseases, including behavioral, developmental and neurological disorders, which constitute a major challenge for sustainable development.

2.2.2 National Policies

A key policy is the National Health Policy. One of the key policy objectives contained in the Kenya Health Policy 2012-2030 is to provide essential health care which is to provide medical services that are affordable, equitable and responsive to client needs.  

The Kenya Human Resource Strategy 2014-2018, identifies the major diseases resulting to death in Kenya as HIV/AIDS at 19%, conditions during peri-natal period 10.9%, lower respiratory infections 8.1% and malaria at 7.2%. In both 2011 and 2012 clinical malaria was the second leading cause of death in Nyanza.

Kenya has long suffered from high maternal, newborn and child morbidity and mortality rates. The Demographic health survey set the maternal mortality rate at 488 deaths per 100,000 live births in the year 2008 compared to 414 per 100,000 in the year 2003. This is well above the MDG target of 147 per 100,000 by 2015.

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15Data from World Bank, 2013.
16Data from United Nations, 2012.
A report on the counties on maternal mortality placed Kisumu as one of the top ten counties with the highest maternal mortality rate with 597 mothers dying out of 100,000 live births. However a report by the Ministry of Health indicates that births delivered at a health facility stood at 69.5 % in Kisumu compared to 61.2% nationally.

There is also the Kenya National Patients’ Rights Charter which was developed in 2013. The aim of the charter is threefold: to empower health consumers to demand high quality healthcare, to promote the rights of patients and to attain highest standard of health to all Kenyans. As one of its objectives, chapter one of the charter lists a plethora of patients’ rights which includes:

a) Right to access healthcare which includes preventive, curative, rehabilitative and palliative care.
b) Right to receive emergency treatment in any health facility irrespective of the patients’ ability to pay.
c) Right to be informed all the provisions of one’s medical scheme/health insurance policy.
d) Right to choose a healthcare provider provided the provider of choice is qualified, registered, retained and in current good standing with the Regulations Authority.
e) Right to highest attainable quality of healthcare products and services.
f) Right to refuse treatment provided that such refusal does not create an immediate danger to the patient or health of others.
g) Right to confidentiality save when the consent to disclose has been expressly given, is allowed by law or is in the benefit of the public.
h) Right to informed consent to treatment.
i) Right to information.
j) Right to be treated with respect and dignity.
k) Right to insurance coverage without discrimination on the basis of age, pregnancy, disability, illness including mental disorder.

The charter further provides for the patients responsibilities and avails a mode for resolving disputes between patients, healthcare providers, employers and regulatory bodies.

2.2.3 County Report/Policy

The Kisumu County Integrated Development Plan (CIDP) 2013–2017 gives information on the health facilities, personnel and supplies in Kisumu. On health facilities it indicates that Kisumu County has 1 provincial hospital 2 sub county hospitals, 16 public health centers, 27 public dispensaries, 27 public dispensaries, 5 private hospitals, 4 nursing homes and 5 private dispensaries, and that facilities offer mostly outpatient services.

On health personnel, the CIDP indicates the Doctor: Population ration to be at 1:44,634 and the Nurse: Population to be at 1:2,383, pointing to insufficient number of doctors in the County.

The CIDP identifies several infrastructure projects ranging from construction of mortuaries, wards. Regarding priority areas these are indicated as follows; a) Reproductive Health, the use of contraceptives is at 27%; that 54% of mothers deliver at home but 71% of them seek antenatal care. Targets to encourage use of reproductive health services, deliveries in hospital, reduce maternal deaths, equip hospitals with staff, supplies are set. Child care, 3.3% of children are severely underweight, 17% moderately underweight, 21.1% moderately stunted and 7.6% severely stunted. Immunization is at 53.6% which is lower than the National average of 80%. Targets set include improve integrated management of childhood illnesses like measles, neo-natal tetanus, pneumonia, diarrhea, malaria and malnutrition and increase immunization/vaccination.

On HIV/AIDS, the CIDP indicates that the National prevalence is 6.3% while that in Kisumu is 11.2%. Threats identified are low uptake and irregular supply of ARVs; negative cultural, socio-economic and religious ideologies; low attitude change (stigma towards use of condoms); low prevention practices and duplication of actions from donors. Targets set include reducing HIV prevalence rates.

On Malaria, prevention and control projects are identified.
3.1 Overall Framework of Right to Health

The purpose of this study is to assess the extent to which the County Government of Kisumu is enhancing the attainment of universal health coverage, including access to essential quality health care services and vaccines for all including reduction of maternal mortality, child mortality, AIDS epidemic, Tuberculosis, malaria, tropical diseases, waterborne diseases and other communicable diseases.

General Comment 14 of the Committee on Economic Social and Cultural Rights outlines essential elements that have an impact the realization of the right to health:

a) Availability – healthcare facilities and programs should be available in sufficient quantity.
b) Accessibility – health facilities should be accessible to all without discrimination, they should be physically accessible, and information concerning health ideas should be accessible. Accessibility should include prisoners and minorities. A health facility must also be accessible in the sense of being affordable.
c) Acceptability – health facilities and services should be respectful of medical ethics and culturally appropriate.
d) Quality – health facility, goods and services should be scientifically and medically appropriate, of good quality, skilled medical personnel, and unexpired drugs and medical equipment.

Firstly the questionnaire for the members of the public sought information on the elements of accessibility, availability, acceptability and quality of service, but added a fifth question on affordability. However to properly assess the availability or unavailability of supplies, machines, personnel, and infrastructure,

20General comment No 14 paragraph 1, 34
the researcher posed the same question to the health administrators and workers, and it is from this information that the research correctly identified the availability or unavailability supplies, machines, personnel and infrastructure of the health facilities.

Secondly, to assess what the County Government of Kisumu has done to reduce maternal mortality, child mortality, AIDS epidemic, Tuberculosis, malaria, tropical diseases, waterborne diseases and other communicable diseases, the questionnaire for the public sought information on whether they had been treated for any of the above illnesses or if so to assess the respective clinics and services.

In addition, the questionnaire for administrators, doctors, clinical officers and nurses specifically sought information on what policies, priorities and programs they had to implement the SDGs which focus on the above illnesses. The Focus Group Discussions with administrators of clinics dealing with these focus areas, also sought to assess how that facility had tried to reduce these illnesses.

Thirdly, to further assess acceptability and quality of the health service in the context of the patients’ rights to treatment while respecting their dignity, quality, choice, information among others, the questionnaires for health administrators and workers sought to test if they were aware of the patients’ rights and how they had practiced them.

Finally, accessibility also includes non-discrimination for prisoners, minorities and other groups. The focus group discussions with the prisons unit and mental health unit sought to assess this aspect.

It is therefore along these sub headings that the findings and recommendations on the right to health are discussed below.
3.2 Implementations of the Right to Health

3.2.1 Kisumu Central

Accessibility: With regard to frequency, 70% of respondents visited the health facilities monthly, twice a month and quarterly (See Pie Chart 3). In assessing physical distance to the facility 94% of respondents accessed the facility within 30 minutes (See Pie Chart 1).

Once they were inside the facilities, 38% were attended to within 30 minutes, while 47% within two hours. The remaining 14% waited for between 2-5 hours and this was mostly at the Jaramogi Oginga Odinga Teaching and Referral Hospital (JOOTRH) and Kisumu East District Hospital KEDH which experienced long queues. (See Pie Chart 2)

On assessment 20% found access to the facility excellent, 68% good and 12% average.

![Pie-chart 1: Distance/Time taken to reach the facility](image)
**Availability:** 41% of respondents were attended to by a doctor at their health facility, while 38% were attended to by other personnel namely, clinical officers and nurses. 97% received information regarding diagnosis and treatment options. 76% had to buy drugs outside the facility. On assessment 35% found availability of service good, 62% average and 3% found it poor (See Pie Chart 4).
Pie-chart 4: Availability of services

Affordability: 85% of the respondents found the drugs affordable when they were in stock. 85% of the respondents found the laboratory services affordable. On assessment 6% found affordability excellent, 70% good and 18% average. (See Pie chart 5)

Pie-chart 5: Affordability
Quality of services: Regarding Professional conduct, 12% of respondents appreciated that staff at the facilities spoke the truth about their disease. Regarding unprofessional conduct 12% of patients raised the issue of nurse’s bad attitude and poor customer service especially at Lumumba Hospital and the KEDH while 3% raised the issue of corruption. On assessment 3% of respondents rated the quality of service as excellent, 44% as good and 53% as average.

Acceptability: Respondents did not give information on any specifics but on assessment 3% rated it as excellent, 82% as good, 3% as average and 12% as poor.

Principles/Priorities of the health facilities: Most facilities in Kisumu Central used the National Health Policy and Local County Principles and prioritized the SDGs especially at the JOOTRH, KEDH and Victoria Annex. This was done through maternal and child health with mother and child care programs, free malaria, HIV and TB treatment with free drugs and health sessions. Only Lumumba did not seem to be aware of the SDGs.

Knowledge of patients’ rights: In all facilities the administrators, doctors and nurses were aware of the rights of patients especially the right to lack of discrimination, information, privacy, confidentiality, privacy while there was increased knowledge by staff of the JOOTRH who were aware of the right to refuse treatment, to access health and emergency treatment and the right to complain.

Staff-patient ratio: In four of the six facilities the doctors and clinical officers saw 50 patients a day while at JOOTRH and AP line, it was 60-70 patients a day. The nurse patient ratio was much better with nurses who, in two facilities, attended to only 7 patients a day, 15-35 patients a day in another three facilities and 50 patients a day in one facility.

Adequacy of medical supplies including personnel at the facilities: Most facilities had inadequate drugs, equipment, lab reagents. In two facilities (AP line and Lumumba Hospital), there was a need for a standard laboratory in Nyalenda and Lumumba Hospital there was need for patient admission wards, at KEDH there was need for a larger maternity unit and theatres while Lumumba hospital requires an emergency room (Lumumba Hospital). Beds and Beddings
were not adequate at JOOTRH and mosquito nets were required at Lumumba Hospital. In all the facilities understaffing was identified as a need, with staff in 4 out of 6 facilities talking about burnouts.

### 3.2.2 Kisumu East

**Accessibility:** On frequency of attending the health facility, most patients visited the facilities weekly (Bar-chart 1). 70% could access the health facility within 1 hour and 30% within four hours (Pie Chart 6). Once in the facility, 72% were attended to within one hour and 14% in two hours and 14% in three hours (Pie chart 7 and Photo 1). On assessment 24% termed accessibility of the facility as excellent 38% as good, 31% as average and 7% as poor (Pie chart 8).

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<thead>
<tr>
<th>No of people and how frequency they access the health facility</th>
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Bar-chart 1: Frequency of attending the health facility
Pie-chart 6: Distance from the facility

Pie-chart 7: Time taken to reach the facility
Photo 1: Patients Waiting at a facility

Pie-chart 8: Accessibility

- 0, Excellent, 7, 24%
- 0, Good, 11, 38%
- 0, Average, 9, 31%
- 0, Poor, 2, 7%
Availability: 40% found a doctor available while 60% found other personnel like a clinical officer or nurse available. Only 50% received information regarding diagnosis and treatment options. 70% found the drugs available, while 30% had to buy drugs for pneumonia, TB, rabies and typhoid at Gita, Orango and Lumumba Sub County hospital. On assessment 24% rated the availability of resources as excellent, 38% as good, 31% as average and 7% as poor (See Pie chart 9).

Affordability: 70% of respondents found drugs affordable, while 73% found laboratory services affordable. On assessment 37% rated affordability as excellent, 30% as good, 20% as average and 7% as poor.

Quality of services: 17% of respondents appreciated the professional conduct and skill of staff as well as the hygiene of the facility. 10% of respondents complained about rudeness of nurses, misdiagnosis and laziness of staff especially at Nyalunya and Simba Opepo. On assessment 23% rated the quality excellent, 33% as good, 33% as average and 10% as poor.

Acceptability: There were no specific indicators of acceptability except that of assessment, where 37% rated facility as excellent, 33% as good, 13% as
average, 3% as poor and 3% as very poor.

**Principles, Policies, SDG:** The guiding principles were transparency, accountability, punctuality, flexibility, honesty, dignity and positivity. The SDG were implemented by; prioritizing reduction of infant and maternal mortality; free vaccinations & immunizations; pre/postnatal clinics; provision of Antimalarial drugs & nets; HIV testing and programs for youth; treatment of water catchment areas by Public Health Officers; sensitization programs and TB/HIV referrals to District Hospital.

**Patient’s rights:** In most facilities medical personnel were aware of patient’s rights to information, quality, refuse treatment, confidentiality, privacy, dignity, non-discrimination and in two facilities these were displayed at the reception.

**Staff Patient ratio:** In half the facilities the Doctor or Clinical officer saw 50-60 patients a day, while in the other half they saw 30 patients. Nurses saw 10-20 patients in four out of six facilities, and 50 patients in two facilities.

**On adequacy of medical supplies including personnel at the facility:** Most health care workers stated that there were inadequate drugs and supplies (gloves, syringes, disinfectants, lab reagents) in all facilities; x-ray, ultrasound, bp, glucometer and typhoid testing (Chiga and Orango) machines; delivery bed at Simba Opepo, Kotunga and Orongo facilities, suction machine & trolley at Kotunga, mosquito nets especially for pregnant women and ambulance services in all facilities.

**Infrastructure:** Chiga and Simba Opepo facilities needed more spacious waiting bays and benches (instead of sitting on the floor); Chiga, Nyalunya, Kotunga, Obwolo and Orango facilities required labor wards; Simba Opepo, Kotunga, Nyalunya and Chiga required laboratories; a counseling room was required at Nyalunya dispensary [as presently unused toilet was being used] (Photo 2); an examination room was required at Chiga dispensary; staff quarters are needed at Gita dispensary. In addition there is a need for running water at Nyalunya dispensary and electricity and security at Nyalunya and Simba Opepo.
3.2.3 Seme Sub-county

Accessibility: Regarding time taken to access the facility 59% were able to reach the facility within 30 minutes, 23% within one hour, 13% within two hours and 5% within four hours (Pie Chart 10). Regarding time taken to be attended while at the facility 48% were attended to within 30 minutes, 23% within 2 hours while 31% had to wait between 2 hours and 6 hours (Pie Chart 11). On assessment 14% rated accessibility as excellent, 42% as good, 34% as average, 5% as poor and very poor respectively (Pie Chart 12).
Pie-chart 10: Accessibility

TIME IN QUEUE

- 0-30 mins: 15, 48%
- 1-2hrs: 7, 23%
- 3-4hrs (Kombewa, Bodi health centre): 5, 16%
- 4-6hrs (Kombewa, Oserwe, Manywanda): 4, 13%

Pie-chart 11: Waiting time

- Excellent: 5%
- Good: 14%
- Average: 34%
- Poor: 42%
- Very poor: 5%

Pie-chart 12: Accessibility
Availability: 45% of respondents found a doctor at their facility, while 55% found a clinical officer or nurse. 62% received information on diagnosis and treatment. 54% found drugs at the facility especially essential drugs like panadol, while 46% did not and had to purchase them elsewhere.

Affordability: 62% found drugs affordable and 71% found laboratory services and admission affordable. On assessment 13% rated affordability as excellent, 47% as good, 20% as average and 20% as poor. Many respondents also complained of being referred to Kombewa which they stated as being expensive for them.

Quality of service: respondents stated that the staff exercised professional conduct by giving reliable diagnosis, nurses being friendly, kind and sincere(Arito Langi) and that the doctor at Onyinjo dispensary was readily available at night. Conversely some respondents identified unprofessional conduct by staff at Kombewa hospital including misdiagnosis, lack of respect, discrimination, laxity, favoritism (of those paying cash over those with NHIF cards), long lunch breaks and keeping very sick patients in the queue. Pharmacists at Miranga dispensary was also found to be unprofessional when they hid drugs and then referred patients to pharmacies they owned. Nurses at Kuoyo Kaila were said
to treat patients badly. On assessment 12% rated the quality as excellent, 50% as good, 33% as average and 5% as very poor (Bodi, Kombewa and Rongo).

**Acceptability:** Asat dispensary was found to be unhygienic due to lack of water which was against the medical ethics, while Kombewa had mixed-sex wards which was culturally inappropriate. On assessment 18% rated the acceptability as excellent, 56% as good, 18% as average, 4.5% as poor and 3% as very poor.

**Principles, Priorities of the facilities:** professionalism, teamwork, standard operating procedures, Fairness (patients served on a first come first served, and priority given to children, elderly; observance of nursing code and Kenya Health Guidelines, teamwork, and Equality were principles applied by the health institutions.

Regarding the **SDGs** there was a focus on

- Maternal/child health - children below 5, pregnant mothers given priority daily health talks on maternal health, importance of delivering in hospital, vaccines, prevent mother to child infection (HIV), mosquito nets after birth, provide pampers, child given prophylactics, follow up for 2 years
- HIV patients given TB preventive medication, HIV – specific clinics, education to eliminate stigma, give ARVs,
- TB, Malaria, waterborne diseases - carry out outreach services on TB, Malaria, waterborne diseases, hygiene programs for waterborne diseases, TB all coughs tested

**Rights of patients:** Right to confidentiality, privacy, consent, no discrimination, information, choice, treatment, Right to access treatment, right to refuse treatment, dignity, confidentiality, Right to information.

**Staff Patient ratio:** in eight out of 12 facilities, staff saw between 20-30 patients a day, in 3 staff saw between 50-60 patients a day while in one the staff saw 10 patients.
Adequacy of medical supplies including personnel at the health facilities: Most facilities reported having inadequate antimalarial drugs (Miranga, Onyinjo), vaccinations (bcg–Rodi); lab reagents, supplies like gloves; typhoid tests, oxygen cylinders; infrastructure like a laboratory, wards including maternity(Onyinjo & Rodi, Asat), staff quarters(Ratta & Miranga), theatre (Manywanda); running water and electricity(Asat); ambulance services and staff and trainings.

Mosquito nets were lacking in four facilities, clean drinking water in two facilities and food supplement for HIV patients. Ambulance services were also unavailable generally.

3.2.4 Vulnerable groups

Article 27(1) and (2) of the Constitution of Kenya states that every person is equal before the law and has a right to equal protection, equal benefit and equal enjoyment of all rights and fundamental freedoms. The Committee on Economic, Social and Cultural Rights in discussing the right to health, state that accessibility should include Equal access – by ensuring non-discriminatory practices of denying or limiting equal access by all persons, including prisoners/detainees, minorities, asylum seekers, illegal immigrants to preventive curative and palliative health services.

It is for this reason that this research seeks to analyse if persons in the categories mentioned and in particular prisoners and mentally ill patients experience any discrimination in the enjoyment of the right to health.

Mentally ill patients

To audit the rights of the mentally ill patients, the research team conducted a focus group discussion with two nurses and one patient at the Kisumu East District Hospital, Mental Unit and came up with the following findings.

Accessibility: When a patient arrives at the facility it takes about 30-45 minutes to see a health provider because the patient has to be clerked like any normal

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21 Article 27(1) & (2), Constitution of Kenya
22 FGD held at the Kisumu East District Hospital on the 20th March 2017, with two nurses and one patient.
patients.

**Availability:** Regarding staff, the unit has seven nurses and one psychiatrist. At the time of the discussion the psychiatrist was on sick leave. The research found that the unit was being assisted by two lecturers from Maseno University Medical School who would visit and see the patients twice a week. The research found that the drugs in the unit were supplied by Kenya Medical Supplies Association (KEMSA), but that these drugs had serious side effects including sedation or drowsiness and restlessness. There was an Electroconvulsive Therapy (ECT) (a machine which gives electrical impulses) which said to be very effective on patients who were non responsive to drugs, but at the time of the visit it had broken down. The facility was meant for 20 patients but sometimes housed 50, and patients are forced to share beds.

**Affordability:** There was a refundable fee of Kshs. 2,000/= on admission. The fee was introduced because it was discovered that many patients were dumped by families, and the unit needed some money to assist the patient locate back home once they had healed. The inpatient fee for the facility per day is Kshs. 600/= and the minimum time that a patient could spend at the facility was fourteen days thus a total of Kshs. 8400/= which most families found expensive. As a result patients remained at the facility waiting for their family members to pay. In many cases, this fee has had to be waived.

**Quality:** The Patient indicated that beddings had bed bugs and that they did not have mosquito nets and the rooms were not sprayed leading to many patients suffering from malaria.

**Acceptability:** To maintain the medical ethics, the facility does not restrain patients except those who were very violent by locking them up in one cell but this practice was rare. The dormitories were separate for males and females. During meal times the patients were allowed to socialize.
Principles, priorities, SDG: The principles that dictate care of all other patients also apply to the mentally ill patients. Regarding the fulfillment of the SDGs, in the past they have conducted outreach programs at Sega. However due to a shortage of staff not outreach programs have been undertaken. It was noted that outreach programs reduced stigma in the community towards the mentally ill and needed to be continuously held.

Patient’s rights: The staff at the unit shared that in many cases observing the rights of the mentally ill was challenging. For example; regarding the right to refuse treatment, the staff confirmed that most mental patients were brought in by family members and therefore their admission was involuntary. In addition during treatment some mental patients did not want to take oral medicine and therefore staff had to administer injections.

The staff at the facility stated that mentally ill patients also had a right to treatment and when ill with other diseases they would receive treatment from relevant units and thereafter returned back to the unit. Regarding the right to dignity, the staff confirmed that at the mental unit, they treated patients with dignity, did not confine them unless if they turned violent and only for a short time. The research however found that when the mental patients would be transferred to other wards, the staff in those wards would not know how to handle them, and there was a risk of isolation and inhuman treatment. With regard to food, mentally ill patients received preferential treatment.

The patient at the facility complained that the staff used a lot of medication to sedate patients. The staff confirmed that the facility lacked the new type of medicines which did not have the side effects of sedation.

Adequate medical supplies: The research found that more staff were required at the facility including psychiatrists, psychologists, psychiatrist social workers, occupational therapists, psychotherapists, nutritionists. The patient requested for more space in the unit as they are crammed in small rooms. The patient also stated that the facilities lacked social amenities such as newspapers, music, sports, TV and pool table.

Prisoners: To audit if prisoners were enjoying the right to health within Kisumu County, the researchers conducted a focus group discussion with the Officer in
Charge, Kodiaga Maximum Security Prison, the Warden in charge of Health, two nurses at the Prison dispensary and hospital and six inmates. In addition the researchers conducted an inspection of the prison dispensary and hospital.

**Accessibility:** Screening is done and medical history recorded of all prisoners who are admitted into the institution to ensure those who are unwell receive appropriate medical attention. Transfer letters for prisoners who are transferred to other prisons indicate any nature of illness and the medication. Within the prisons, a duty warden stationed in close proximity of the cells provides first aid to prisoners and checks their health-being. The duty warden refers inmates to the dispensary when unwell. In cases on emergencies in the night, the prisoners would knock at the duty warden’s door who would ensure they are taken to hospital.

**Availability:** The facility has 9 nurses, 4 lab technicians, 2 pharmacists and 1 clinical officer. In addition they have a psychiatric nurse attached to the facility to deal with mentally disturbed patients. Only one nurse was available on inspection and the nurse on duty confirmed that he attends to 30 patients daily. Regarding drugs, the nurse confirmed that the essential drugs provided by KEMSA were mostly available, and when they are out of stock, the warden in charge of health would be notified, when essential drugs are out of stock, the prison would source the drugs from donors like Coptic Church and the prisons headquarters who often provided HIV drugs. The prison hospital has an inpatient capacity of 24 beds and at the time of the visit only 8 were occupied. There was an ambulance available to refer serious cases to main referral hospital -JOOTRH.

**Affordability:** There were no occasions when prisoners were asked to buy drugs from outside the facility.

**Quality:** The facilities appeared clean and no unprofessional conduct was observed. At the hospital, patients were given meals of reasonably good quality. Additional supplements were given for HIV and diabetes patients and the researchers witnessed milk supplements being given out.

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23 FGD held on 20th March 2017 with the Officer in Charge, Senor Assistant Commissioner of Prisons Mr. Mwakazi, Mr. Gideon Naete, Nurse at Prison Dispensary, Mr. Isaac Aweor, Warden in charge of health, Ms Jacinta, Nurse at Prison Hospital.
Acceptability: The facility observes the medical standards and is acceptable even to the general public who accessed the hospital.

Principles, Priorities, SDG and Patient’s rights: Regarding the SDG’s there was special treatment given to certain patients such as TB patients who are isolated to a separate G-block; HIV patients who are given special diet of potatoes, rice fruits, milk and food supplements from Health Strat. In addition the HIV patients attend the dispensary daily to take their ARVs. The mentally ill patients were segregated and treated by the psychiatric nurse within the facility as well as a counseling psychiatrist from JOOTRH who visited weekly. The elderly prisoners are accommodated in one cell easily accessible to the dispensary.

On communicable diseases, public health officers inspect the cells daily to ensure cleanliness. In cases of overcrowding, prisoners are transferred to other prisons within the County. In addition, the Public Health Officers inspect the kitchens and taste food to ensure safety and cleanliness of the meals. Those who work in the kitchen are also given a health check to ensure that no disease is spread through the food. As a preventive measure one of the inmates interviewed requested for more frequent spraying of insecticide because of mosquitoes and bed bugs.

Patient’s rights: The research found that patient’s rights are respected for example the right to dignity (patients are not handcuffed while being treated). In addition the right to confidentiality is upheld, and the nurse confirmed that although the HIV patients are divided into peer groups for support, the health providers do not share this information with other patients. The right to non –discrimination – the nurse at the hospital confirmed that prisoners and members of public at the facility are treated the same with regard to their rights.

Adequacy of medical supplies and other challenges: The Commission established the following challenges;

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24 Health Strat is a US funded, Centre for Disease Control (CDC) managed program to support prisons in Kenya with HIV and TB drugs.
1. Insufficient funding and the institution has to refer seriously ill patients to other facilities due to prohibitive cost of treatment for such ailments. Patients who are referred to other facilities are assigned a prison warden and this creates a problem.

2. Prison congestion- at the time of the visit, the prison had by over 1200 inmates transferred from Naivasha Maximum Prison. The Officer in Charge was working out a plan of distributing these prisoners to other facilities within the County.

3. Water shortage within Kisumu as a County affects sufficient supply and access to water within the prison facility. The Officer in Charge stated that in the past the facility utilized water from Lake Victoria but due to due to pollution the facility’s water source is a seasonal spring. During dry season, the spring water is rationed but priority is given to the prisoners.

4. Delayed or failure to supply quarterly medical supplies by KEMSA has seen the medical facilities depend on supplies from donors or the prison central administration.

5. Shortage of staff, especially clinical officers specifically employed to serve the prison. Currently, they are employed by the County Government and could be transferred to other health facilities on short notice. At the time of the inspection, there was only one nurse to attend to 30 patients from one block daily, other nurses were on leave while other had been transferred.

6. Language barrier between the medical staff and patients. The nurse shared that some prisoners only spoke their mother tongue thus requiring translators when seeking treatment.

HIV/AIDS Unit and Maternal and Child Care Unit.

The researchers conducted an audit of HIV/AIDS clinic and the Maternal and child care clinic through a focus group discussion at the JOOTRH and had the following findings.25

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25FGD at JOOTRH on the 22nd March 2017, with three administrators/nurses in charge of these units
1. The Administrators of the HIV unit and maternal and child care units referred to the National Health Standards and the Nursing standards as their guiding principle in provision of health care.

2. In keeping with the SGDs, the Commission established that priority given to HIV, Communicable (TB, Malaria) and Maternal and child care in the form of special clinics to offer the specialized care.

3. The Commission established that the personnel were aware of and observed patient’s rights. The medical personnel were aware of the right to information, choice, treatment and confidentiality. However, they shared that at times patients violated or endangered other people’s rights. For example, where expectant HIV positive mother would refused to take necessary medication and care to prevent mother to child infection citing right to refuse treatment. This action would then endanger the life of the foetus; and patient who frequented a facility for HIV/Aids or STI treatment and confirmed that they had not disclosed medical information to their partners/spouses, the medical personnel would not disclose medical information due confidentiality.

4. On reproductive rights, the Commission established that women seeking family planning services are given various options and allowed to choose the most appropriate for them. Unfortunately, after administering the appropriate service, most women would return seeking reversal citing conflict with their spouses/partners who demanded to give consent. The facilities have resolved to counsel couples for them to make appropriate family planning choice and avoid conflict.

5. On abortion, the Commission established that health workers support women to procure medical abortion in cases where pregnancy is as a result of defilement, rape or incest. The health workers noted that from experience when survivors of sexual violence are allowed to carry the pregnancy to full term against their will, they end up suffering psychologically and when they deliver they abandon the children in the health facility or intentionally harm the child.

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26Protocol to the African Charter Article 14, 1(e) – it is a right for a spouse to be informed if their spouse has HIV/AIDS or STIs
6. In cases involving persons with disability or children who are in danger and seek medical help, the hospital administrators would refer such cases to the relevant institutions including the children’s department and the Gender Violence Recovery Centre.

7. It was reported that the health facilities had insufficient delivery beds and other medical equipment.

### 3.2.5 County Government of Kisumu

The researchers carried out an interview with County Executive Officer in-charge of Health in the County Government of Kisumu and thereafter received a filled questionnaire from the ministry which gave the following findings.  

According to the Kisumu County Integrated Development Plan 2013-2017, the number of public facilities are as follows:

- **National Referral Hospital** – 1
- **Sub-County Hospitals** - 2
- **Health centers** - 16
- **Public Dispensaries** – 27

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27 Interview on 21st March 2017 with Dr Elizabeth Ogaja, Minister of Health, County Government of Kisumu.
The number of private facilities was as follows:

- **Private Hospital** – 5
- **Nursing homes** – 4
- **Dispensaries** – 5

However, during the interview with the CEC in-charge of Health indicated that the number of Health Centers were 23 and Public dispensaries as 27.

The Number of doctors working in Kisumu County is 163 for both public and private facilities and are assigned in different facilities as follows:

a) **Referral Hospital** – 88
b) **Kisumu County** – 23
c) **Sub counties/CHMT** – 27
d) **Other (Private) County Hospitals** – 25

There are 802 nurses in the County.
A study conducted by KIPPRA on health professionals in Kenya\textsuperscript{29} indicated that in 2010/2011 Kisumu County had 65 doctors and 676 nurses. The study projected a shortfall of doctors in 2013 by -37 and an increase of nurses at +16. The CIDP 2013 - 2017 also indicated that the doctor to population ratio was 1:44,634 and nurse to population ratio is 1:238. A bleak picture is however painted by the draft County Health Policy\textsuperscript{30} which showed that the number of doctors in 2012 stood at 247 against a population of 1.3m, then dropped to 210 in 2015 and further dropped to 163 in 2017. On nurses, the draft Policy show that in 2012 the number of nurses was 910 against a population of 1.3m, the number dropped to 378 in 2014 and now stands at 802 in 2017.

The CEC health blamed the loss of staff on the unclear duties of those seconded from the National Government to the County Government and who found it difficult to work under the County Government. She also alluded to the lack of finances to pay the staff adequately and cited the numerous labour strikes that had occurred.

The County has developed a Draft Health Policy which is yet to be adopted by the County. The Commission established that the draft policy borrowed heavily from the WHO Global policies including; the 1978 8 pillars of health;\textsuperscript{31} Integrated Disease Surveillance and Response (IDSR)\textsuperscript{32} and International Health Regulations. Other guides included, the Sustainable Development Goals as well as the National Health policy.

The draft policy had prioritizes the following areas:

\begin{itemize}
  \item HIV/AIDS
\end{itemize}

\textsuperscript{29}Health Professionals in Kenya: Estimation of minimum County requirements, KIPPRA Discussion paper no 163/2014
\textsuperscript{30}Health Policy, Kisumu County www.healthpolicyproject.com/pubs/291/KisumuCounty-Final
\textsuperscript{31}8 pillars of health originated from a WHO policy adopted in 1978 with the aim of incorporating a preventive element to the treatment of health in developing countries and this policy therefore established the importance of the Primary Health Care adopted in the Alma Alta Declaration of 1978. A report by The World Health Organization in 2008 found that the populations in those countries with strong general practice have lower rates of ill-health and mortality - Better access to care by all members of the community - Lower rates of people being readmitted to hospital after treatment - Fewer consultations with consultant specialists - Less use of emergency services - Better detection of adverse effects of medication interventions. The role of the GP is increasingly important as the population ages and the increases in the burden of chronic disease require continuing long-term care. A primary care system that is adequately funded ensures value for money by providing patients with the right care at the right time, in the community, thereby reducing costly preventable hospital admissions. http://www.who.int/whr/2008
\textsuperscript{32}IDSR is a strategy of the World Health Organization Regional Office for Africa for improving epidemiologic surveillance and response in the African region. http://www.afro.who.int
• Communicable diseases like HIV, TB, diarrhea and malaria
• Reproductive, Maternal, Neonatal and Child Health - Kisumu is one of the 15 counties which has the highest rates of maternal and infant mortality. As a result the policy aims at reducing maternal mortality and infant mortality and supporting the health of children under 5yrs including malnutrition.
• Diarrhea diseases
• Pneumonia
• Malaria
• Injuries – especially those caused by motor vehicle, motorcycles and bicycles
• Non communicable diseases – diabetes, cancer, hypertension, obesity

The Draft County Health policy provides for the following:

I. Community health – recommends that more focus and resources be spent at the community level, by establishing general practitioners who would be tasked with the primary care and only engage consultants at referral stage. This would significantly reduce the cost of consultants who could then be employed on contract.

II. Community level Financing – There should be an uptake of insurance schemes for every Kenyan so as to ensure protection in times of sickness, including the use of NHIF scheme

III. Information systems and data - the use of Vital, confidential useful information is obtained from patients by health workers to guide the health policy or interventions.

IV. Human resources – the use of The World Health Organization’s formula for calculating the health professionals needed in a certain population\(^{33}\) to promote efficiency and reduce burnout. Focus on human resources should not only focus on doctors and nurses but other professionals such Laboratory and pharmacy technicians.

V. Governance- the health functions between National and County

\(^{33}\text{WHO (2010) ‘WHO handbook of indicators for HSS ’ www.who.int/healthinfo/systems}
Government needs to be properly coordinated. Properly governance structures will be established

VI. Legal framework – the adherence and proper application of the law including laws relating to medical ethics, standards, duties and rights of all players including patients and the right to emergency care even in times of strike

The Minister also indicated that the County Government of Kisumu in formulating their policy needed to look at what contribution was made by the drivers of health namely:

a) Environmental factors - such as global warming and its effect on agriculture. How this affect food production and increases cases of malnutrition

b) Water & Sanitation - how inaccessibility of clean and safe water may cause waterborne diseases i.e. cholera,

c) Transport sector - where persons in the transport sector don’t adhere to safety rules, they get injured hence increasing the number of orthopedic patients

d) Insecurity & Crime including transnational crimes like drug trafficking which has resulted in prevalence of drug abuse thus creating need for establishment of programs for drug addicts.

e) Economics of health – HIV, malaria have been depleting funds from the health budget. There is a need to think about reducing costs for running the health facilities like solar power instead of electricity.

At National level, the human rights principles from the ICSECR, African Charter, and Constitution of Kenya sc. 43 were integrated in the National Health policy. However at the County level, they had not incorporated these principles and not many administrators, doctors and nurses were aware of these rights.

The SDGs had been clearly communicated to the health practitioners and administrators. The County has prioritized HIV, Malaria, communicable and waterborne diseases, maternal and child health in the health facilities. For
example on dealing with Malaria menace, the County is engaged in destroying mosquitos’ breeding nests and in reducing maternal and infant mortality, the hospitals hold mandatory monthly meetings to discuss and remedy any incidences related to maternal or infant mortality.

Measures taken by the County Government of Kisumu taken to enhance delivery of health services.

To enhance service delivery, the County government has undertaken the following;

a) Construction of health facilities
b) Equipping health facilities
c) Attracting and retaining skilled work force
d) Promotion/prevention of diseases using community strategy
e) Universal access to ART for HIV infected people
f) Improved drugs supply through KEMSA

**Challenges faced by the County Government of Kisumu in actualizing the Right to health**

The CEC in charge of health shared the following challenges faced by the County in actualizing the right to health;

a) Insufficient budgetary allocation- insufficient funds hindered the recruitment of staff, purchase of equipment and construction of necessary infrastructure. The budget priority for the County has been to build other infrastructure. The Commission established that there was an increased budgetary allocation for health sector as below:

<table>
<thead>
<tr>
<th>Year</th>
<th>Budget (Kshs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016-2017</td>
<td>2,567,888,768</td>
</tr>
<tr>
<td>2015-2016</td>
<td>2,369,701,000</td>
</tr>
<tr>
<td>2014-2015</td>
<td>2,343,205,726</td>
</tr>
<tr>
<td>2013-2014</td>
<td>1,898,956,481</td>
</tr>
</tbody>
</table>
The Kenya budget analysis however indicates this amount as slightly higher putting the 2013/14 health budget at 2b working out to about 19% for both 2013/14 and 2014/15. Out of that amount just over 80% was used for recurrent expenditure (personnel and operations) while only 20% was used for development. 34

b) There was a marked improvement in the year 2015/16 where the health budget was 24.5% of the total budget, 60% of that amount spent on employees’ salaries, 29.6% on operations and management and 10% on development. The trend continued in 2016/17 budget, where 25.6% was allocated to health, 59% of that amount covering the cost of paying personnel, 30% to Operations and Management and only 10% to development. The County Government of Kisumu in their CIDP committed spending the bulk of the development funds on infrastructure for health such as rehabilitation of health centers and construction of dispensaries, wards, mortuaries and maternity wards. 35. Due to limited funds, the County is not able to employ sufficient health personnel as recommended by WHO. Currently with an estimated population of 1,145,749 the County has 163 doctors and 802 nurses.

c) Focus Another challenge that the Minister raised was that the draft health policy had focused on the achievement of areas highlighted in the SDGs. She stated that there was a high burden of non-communicable diseases, high maternal maternity at 597 per 100000 live births, high under five mortality at a rate of 74 per 1000 live births and high burden of communicable diseases like HIV with a prevalence of 19.3% against the national rate of 5.3%. Due to this there were no resources to focus on other health needs for example drug addiction by youth, community programs to educate population especially in the area of mental health.

d) Further supervision of private sector including chemists who often sell antibiotics across the counter sometimes without a prescription or antibiotics for diseases that do not need an antibiotic, resulting

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35Kisumu County Budget 2015-2016 and 2016-2017. Also see KCIDP document. www.kisumu.go.ke
in increased resistance to antibiotics resulting in poorer health of population.

e) Training of Health workers on Human Rights principles.

f) There is a need to train all health workers on the rights of workers as contained in the

g) Areas of training would be on the following.36

h) The patients right to the highest attainable standard of health including reproductive rights and emergency services

i) The patients right to the highest attainable standard of physical and mental health

j) The patients’ rights to available, accessible, acceptable and quality health facilities

k) The patients right to refuse treatment and consent to treatment

l) The patients’ rights to be treated with respect and dignity

36Article 43 of the Constitution of Kenya, Article 12 of the ACHPR, Sustainable Development Goals and Patients charter
4 CONCLUSION

4.1 Summary and Recommendations arising from findings.

4.1.1 Kisumu Central

There following areas affect the provision of health in Kisumu Central.

Accessibility: 15% of respondents took between 2-5hrs to be attended to while at JOOTRH and KEDH. Only 41% of respondents found a doctor at the facility while 38% were attended to by a clinical officer or nurse. The doctor: patient ration in these two facilities was found to be 1:60-70 patients a day and that of nurses at 1:35-50. This explains the long hours that patients have to wait for the service. It also explains why staff in these facilities complained of burn-out.

Recommendation: There is an urgent need for an increase in the number of skilled health workers and in particular doctors, nurses and clinical officers from a density of 1.19 to the recommended density of 2.3 per 1000 patients at all facilities but especially at JOOTRH and KEDH, so as to avoid staff burn out.

On availability of drugs, the research found that when the drugs were available, 70% of patients found them affordable, while the other 30% did not. The research found that an alarming high figure of 76% of patients had to buy drugs from an outside facility due to lack of availability with most patients purchasing drugs at the chemists opposite the hospitals or in town. The most affected hospital was the referral hospital (JOOTRH), followed by the Kisumu County District Hospital. The hospital which had drugs at all times was the Victoria Annex. The drugs which were not available included drugs for treating malaria, typhoid, amoeba and dog bite., Is it possible to get more details... what kind of drugs are these/ at what cost? What is the demand? Can we be
more particular in the recommendation.

**Recommendation:** There is an urgent need to stock enough drugs at all facilities in Kisumu Central and in particular drugs for common diseases such as malaria, typhoid and amoeba.

**On Quality,** 12% of respondents raised issues of nurses’ bad attitude in handling patients especially at Lumumba Hospital and KEDH.

**Recommendation:** There is need to train nurses on professionalism, patient’s rights and anticorruption practices. Although the patients charter allows patients to complain, the research found that some staff were not ready to receive these complaints especially where the staff were overworked and there is a need to introduce a structured complaint mechanism, either through a suggestion box or a specific officer for that purpose and performance targets for the staff. What can be introduced complaints mechanism? Performance targets

**On SDGs** – staff at Lumumba Hospital did not seem to know what SDGs were and training on this is necessary.

**On Adequacy of medical supplies,**

This information was obtained from interviews with the health workers namely the doctors, nurses and clinical officers and the hospital managers. In six health facilities the research found that there was need for more and consistent supply of drugs namely (JOOTRH, KEDH, Nyalenda Health Centre, Lumumba Hospital, AP line health centre and Victoria Annex). Three out of the six facilities required supply of laboratory reagents (KEDH, JOOTRH and Lumumba). Five facilities required more equipment (AP line, JOOTRH, KEDH, Nyalenda and Lumumba). A laboratory was required in two facilities namely Lumumba Hospital and AP line. There was also need for construction of an enlarged maternity ward at KEDH, general wards at Nyalenda and Lumumba hospitals and an emergency room and offices at Lumumba Hospital.

Regarding staffing needs at the facilities, in four of the six facilities the doctors and clinical officers saw 50 patients a day while at JOOTRH and AP line, it was 60-70 patients a day resulting in burnout. The nurse patient ratio was
better with nurses in two facilities seeing only 7 patients a day, in another three facilities seeing between 15-35 patients a day and in one nurses seeing 50 patients a day.

There is a need for the County Government of Kisumu to supplement the drugs supplied by KEMSA and laboratory reagents. The CGK should also invest in equipment and infrastructure.

We need to break this done what did we find what exactly are we recommending. Like distribution of laboratories etc

The research found some positive aspects to provision of health in Kisumu Central.

**On Quality**, 12% of respondents verbalized their appreciation for the professional conduct of the staff in speaking the truth about their illness, which is reflected by 97% of them receiving information regarding their diagnosis and treatment.

**Summary**

Accessibility to the hospital and attendance once in the facility was quite good except for 15% who took between 2-5hrs to be attended to. Only 41% saw a doctor, due to understaffing resulting in burn out. There was a serious shortage of drugs with 76% of respondents having to buy them from an outside facility. Many staff exhibited professional behaviour taking time to give the patients the necessary information regarding the diagnosis and treatment of their illness, except for a few nurses at two facilities. More doctors should be employed.

### 4.1.2 Kisumu East

There were some areas of Strength within Kisumu East.

**On Accessibility**: 80% of patients could access the facility within one hour and 74% were attended to within one hour of accessing the facility.

**On Availability**: 70% found the drugs available at the facility.
On Affordability: 70% of respondents found drugs affordable, while 73% found laboratory services affordable.

On Quality of service – 17% of respondents appreciated the professional conduct and skill of staff as well as the hygiene of the facility.

There were some areas of weakness within Kisumu East.

On Availability, only 40% of patients found a doctor at the facility. The effect of this is that only 50% of patients received information regarding the diagnosis and treatment options. The doctor: patient ratio in half of these facilities was 1:50-60.

Recommendation: Need to employ more doctors at the facilities.

On Quality of service – 10% of respondents complained about rudeness of nurses and misdiagnosis at Nyalunya and Simba Opepo.

On Adequacy of medical supplies including infrastructure, the following lacked - typhoid testing machines in Orango and Chiga, x-ray and ultrasound machines, bp, glucometer machine, delivery beds in three facilities (Simba Opepo, Kotunga and Orongo), mosquito nets especially for pregnant women and ambulance services at all facilities.

On infrastructure required three facilities needed a more spacious waiting bay and benches instead of sitting on the floor, five facilities required labor wards, four facilities required laboratories, counseling room, examination rooms, running water(Asat), electricity, security (Nyalunya and Simba Opepo).

Recommendation: Need to purchase machines, delivery beds, mosquito nets and an ambulance. There is also a need to invest in infrastructure in all facilities and provide running water in Asat and electricity and security in the two facilities.

Summary

Accessibility to the facility and availability of drugs seems to be good. However once in the facility only 40% access a doctor and only 50% receive information regarding the diagnosis and treatment of their illness, due to inadequate staff.
In addition staffs in some facilities are rude. The greatest area of need is infrastructure where five facilities lack labour wards, four lack laboratories, others counseling rooms, examination rooms, waiting bays, running water, electricity and security. Mosquito nets for pregnant women, typhoid testing, bp, glucometer machines are also lacking as well as ambulance services.

4.1.3 Seme

On Accessibility: 82% could access the facility within one hour and 68% were attended to within one hour of reaching the facility. But 31% had to wait for between 2-6 hours within the facility and specifically at Kombewa, Oserwe and Manywanda.

On availability only 45% found a doctor but only 62% received the health information regarding their diagnosis. 54% of respondents found drugs and 62% found drugs affordable when they were in stock while 71% found laboratory services affordable when available.

On adequacy of medical supplies - Antimalarial drugs are needed at Miranga and Onyinjo, BCG vaccinations at Rodi; lab reagents, supplies like gloves; typhoid tests, oxygen cylinders; infrastructure like laboratories at in four facilities, maternity wards in four facilities, theatre, staff quarters in two facilities, running water and electricity in one facility and ambulance services in all facilities.

On quality of service some respondents noted professional service from doctors and clinical officers who gave reliable diagnosis, nurses at Arito Langi who were friendly, kind and sincere and the doctor at Onyinjo dispensary who was readily available at night.

Unprofessional conduct was also noted on the part of staff at Kombewa hospital and Kuoyo Kaila including misdiagnosis, lack of respect, discrimination, laxity, favoritism (of those paying cash over those with NHIF cards), long lunch breaks and keeping very sick patients in the queue. In addition the Pharmacists at Miranga dispensary were also found to be unprofessional when they hid drugs and then referred patients to pharmacies they owned. 5% of respondents rated
the quality as very poor and in particular from Bodi, Kombewa and Rongo).

**Recommendation:** Nurses at Kombewa and Kuoyo Kaila need to be trained on patient rights and the allegation over the Pharmacist(s) at Miranga investigated.

**Summary**

31% of patients have had to wait for between 2-6 hours to see a doctor and only 45% of them eventually do which is why only around half of them receive information regarding their diagnosis and treatment. The failure to have drugs available for 46% of the patients, who have to buy drugs, negatively affects the rating for Seme, where only 47% rate the affordability of service as good, 20% as average and 20% as poor. In addition the quality of service especially at Kombewa Hospital is poor with staff misdiagnosing and mistreating patients resulting in a rating of 33% average of 5% as poor. Supplies like antimalarial drugs, vaccinations and lab reagents are unavailable as well as infrastructure like maternity wards and laboratories in three facilities and theatre in one. It appears that many patients are referred to Kombewa Hospital, which they find unaffordable. There is an urgent need for more staff, drugs, training of staff to respect patients and focus on building of maternity wards and laboratories.

**4.1.4 Kisumu East District Hospital (Mental Unit)**

📍 On accessibility it took 30-45 minutes for a patient to be attended to see a health practitioner once inside the institution which was reasonably good.

✔️ On availability there was no psychiatrist as the one available was on sick leave.

Only essential drugs were available and not the new improved ones with fewer side effects. This assertion was supported by the patient who stated many patients at the facility were subject to a lot of medication resulting in sedation.
The ECG which the nurses used for treatment of non-responsive patients had broken down.

Although the facility was meant to accommodate 20 patients, it often accommodated up to 50 patients who would share beds. The patient interviewed complained about the small space available.

**Recommendation:** Urgent need of psychiatrist, new improved drugs, repair of the ECT machine, more beds or a bigger facility.

**On Affordability,** The staff confirmed that the charges for the unit were Kshs. 600 a day, and the minimum time a patient could reside at the facility was two weeks bringing the bill to Kshs. 8400/= which was too expensive for most families, but which could be waived by the welfare office if good reason was given. In addition the facility had introduced a refundable fee of Kshs. 2000/=.

**Recommendation:** The daily rate of Kshs. 600/= to be reduced.

**On quality** the patient stated that they did not have mosquito nets and that the beddings had bed bugs.

**Recommendation:** Frequent spraying of rooms and beddings with insecticides.

**On acceptability** the patient stated that the facility lacked space and social activities which resulted in boredom.

**Recommendation:** Need for bigger space, introduction of social activities, newspapers, music, sports, television and pool table.

**On adequacy** of medical supplies the staff stated that there was an urgent need for more and variety of other specialists including psychiatrists, psychologists, psychiatrist social workers, occupational therapists, psychotherapists, nutritionists. They noted that in the past they used to conduct community programs, which had seized due to lack of staff.

**Recommendation:** More and specialized staff to be employed. Community outreach programs to continue.
On Patient’s rights, the research found that where mentally ill patients were transferred to other wards to be treated for other diseases, staff in those wards, who had not been trained on how to handle mentally ill patients, usually feared, stigmatized and isolated the patients.

Recommendation: There is a need for other staff within the facility to be trained on how to handle mentally ill patients so as to avoid the stigma and isolation.

Summary

Regarding mentally ill patients, there is unavailability of staff including psychiatrist, psychologists, psychiatrist social workers, occupational therapists, psychotherapists and nutritionists. In addition the new improved drugs which have reduced side effects of sedation are not available. The ECG machine which is said to be very effective on the non-responsive patient’s had broken down. The facility meant to accommodate only 20 patients, sometimes accommodated more than double that number leading to overcrowding and sharing of beds. The standards of hygiene and acceptability did not seem to be observed due to the infestation of bedbugs and mosquitoes. When ailing from other diseases, these patients would be released to the other wards, but due to lack of training of the other staff, were subject to stigma, isolation and probably violation of their human rights. The need to introduce Kshs. 2000 as a refundable fee due to cases of families dumping their patients at the unit, points to a lack of information about this illness. The community outreach programs seem to have halted, due to shortage of staff. There is therefore an urgent need to increase community programs about the care and rights of this vulnerable group. The one positive comment was the preferential treatment that the mentally ill patients received from the hospital kitchen.

4.1.5 Kodiaga Prison

On Accessibility: The research found the access to the medical dispensary was quite easy during both the day and night, and availability of an ambulance made referrals fast.
The facility has 9 nurses, 4 lab technicians, 2 pharmacists and 1 clinical officer and a psychiatric nurse, although only one nurse was available on inspection and he nurse that he attended to 30 patients in a day.

The research found that there were sufficient drugs from KEMSA and the presence of a warden in charge of health helped in sourcing other drugs from the central administration and donors in times of stock-out.

The prison hospital had an inpatient capacity of 24 beds and at the time only 8 were occupied.

**Recommendation**: There is need for a clinical officer.

**On Quality** the research found that the prisoners were generally satisfied with the service offered. They however stated that the cells were infested with bedbugs and mosquitoes.

**Recommendation** more frequent spraying of insecticides to eradicate mosquitoes and bed bugs necessary.

**On adequacy of supplies and challenges**, the Officer in-charge also shared that referring prisoners to other hospitals required 24 hour surveillance of guards and a risk to the public. He also stated that the source of water was a temporary river which dried during dry season.

**Recommendation**: need for specialized services to cater for serious cases. Need for reliable water source.

**Regarding the SDG’s** this facility paid special attention to certain groups of patients namely the TB patients who are isolated to a separate G-block; HIV patients who are given ARVs, special diet of potatoes, rice fruits, milk and food supplements from Health Strat; mentally ill patients who were segregated and treated by the psychiatric nurse within the facility as well as a counseling psychiatrist from JOOTRH who visits weekly and the elderly prisoners are put in one cell which has easy access to the dispensary both day and night.

In addition the facility public health officers inspect the cells daily to ensure cleanliness, the kitchens and taste food to ensure cleanliness is observed and examine those working in the kitchen to ensure that no disease is spread through the food.
Regarding Patient’s rights in a bid to confirm if the rights of the patients were being observed and in particular the right to respect, dignity, confidentiality and equality the research found that the patients were treated with respect and dignity and staff never used force either physical (handcuffs), emotional or otherwise, observed confidentiality and did not discriminate in any way against the patients.

Summary

Regarding prisoner’s rights there appeared to be observance of their right to health. On accessibility this was found to be quite easy and fast due to the inmate first-aiders. Although many staff exist, some were on leave or on transfer and at the time of the inspection the nurse was seeing 30 patients a day (against… recommended). There is therefore a need to employ permanent staff for the prison hospital to avoid frequent transfers or unplanned leave. There appeared to be sufficient drugs, inpatient wards and ambulance services. There is need to equip the hospital further with machines and staff to cater for serious cases. There were no cases when staff had to purchase supplies. On quality and acceptability, it appeared that the staff were aware of the patients’ rights and treated them with dignity. The facility paid special attention to the HIV/Aids patients, TB, mentally ill, elderly by isolating them, giving them food supplements and easy access to the medical facility.

4.1.6 JOOTRH – HIV/AIDS; Maternal and child care

The Focus Group Discussion did not specifically focus on accessibility, availability, affordability, quality and acceptability of the services offered by the units, as the facility had already been audited during the research.

The research found that most of the patients who attended this facility came for the primary treatment and not on referral. Only those who attended the clinics had been referred from their health centres. This includes the HIV/AIDS, Maternal and child care, Eye clinics due to more specialized care. As a result, patients had travelled from all over Kisumu County. Once in the facility, they confirmed that because of the high volumes of patients, the staff: patient
ratio was very high (1:60-70 patients) and thus the long waiting queues (of between 2 and 5 hours before patients were attended to).

The research revealed that the staff at the Maternity unit were overstretched where the nurse on duty had delivered 50 babies over one weekend. The maternity unit lacked enough delivery beds resulting in mothers delivering on the floor. This was particularly severe during the doctors’ strike where other facilities who would ordinarily offer maternity services had referred patients to the JOOTRH. The research revealed that this high number compromised quality due to the large volume of work.

The focus of the discussion was on the priority areas, principles, adherence to the SDGs, patients’ rights and adequacy of the supplies and any challenges.

On **Priority areas and principles** the staff quoted the Nurses code of conduct which provides that nurses should treat patients with dignity, equality and that all individuals, families and communities should be involved in the management of their health. They also indicated that the nurses guiding principles included integrity, professionalism, service delivery, respect, justice, transparency and accountability among others.

On **SDGs**, the research found that the facility had set up clinics to cater for the treatment of vulnerable groups as set out in the SDGs namely the HIV/AIDS, communicable diseases (Malaria, TB, waterborne), Maternal and Child Care. Through the report we make no mention of figures when we mention SDGs and yet SDGs are all about the ability to measure etc? How do we package this so that we demonstrate that the County is not only aware of the principle but also working to meet the targets?

On **patients’ rights**, the staff appeared to have a good understanding of patients right’s to treatment, confidentiality, privacy, dignity, choice of treatment, to refuse treatment. They report found that these rights were sometimes practiced to the detriment of others like in the case of a mother infected with HIV/AIDS, who refused treatment, her unborn child would be at risk. In the case of a patient who had STIs, but insisted on their right to confidentiality, the staff was unable to inform the spouse, exposing them to risk.

37 Code of Conduct and Ethics for National Nurses Association of Kenya (NNAK) www.eacc.go.ke
The staff stated that certain rights should be exercised like a woman’s right to abortion if the foetus is as a result of rape, incest, as this resulted in mental and physical anguish for the patient.

Regarding **adequacy of medical supplies** the research found the understaffing was the biggest challenge. The WHO gives a minimum threshold of 2.3 doctors, nurses and midwives per 1000 population as necessary to deliver essential maternal and child health services, but the research found that this had not been achieved.38.

In addition there is a lack of enough drugs even for common diseases like malaria and delivery beds in the maternity unit. More Community workers are needed to talk to patients to follow the advice of the doctors especially the HIV patients who neglect to take their medication.

**Recommendation**: More staff should be hired at the JOOTRH to reduce the waiting times. The Institution should have a Patients Charter and service charter of the hospitals visibly on display in order for patients to know their rights.

**Summary**

With regard to the **vulnerable focus groups** stated in the SDGs – JOOTRH had set up special clinics for treatment of these groups and because it was a referral hospital, patients travelled over both short and long distances. Once inside the facility, due to shortage of staff, they had long waiting hours. The doctors and other medical staff were inadequate as was the drugs. Regarding quality JOOTRH recorded positive comments regarding giving of correct information about the diagnosis and treatment of the patient. Regarding policies and priorities, SDG it was very clear that at the JOOTRH the administrators have programs to try to reduce the illnesses and advised the patients on how to avoid or reduce the illness. The administrators had a good understanding of the patient’s rights and in some cases struggled with the violation that the right caused as in the case of HIV infected mother refusing treatment and putting their unborn children at risk; risk to a spouse of a HIV or STI infected patient. There was need for more staff, drugs and training on how to balance the patient's rights.

38http://www.who.int/hrh/workforce_mdgs/en
4.2 County Government Of Kisumu

4.2.1 What strategies has/can the CGK take to promote health care for all?

Regarding drugs, at most facilities KEMSA was lauded for provision of necessary drugs but the CGK should subsidize KEMSA especially at JOOTRH and the KEDH.

By setting targets with regard to the HIV/Aids; Maternal and Child Care; Malaria, TB, communicable and waterborne diseases, there was evidence that these programs were running at the facilities with the effect of increasing health care for all.

The ratio of staff to patients is high and does not meet the recommended density of 2.3 per 1000 patients. There is a need to hire more staff. The CGK also needs to ensure that there are necessary equipment, and infrastructure in all facilities and not only at the Referral and Sub-county hospitals.

4.2.2 What strategies can CGK take to promote health for vulnerable?

The Research found that by following the Global Policy and National Policy, the County had prioritized the areas highlighted in the SDGs in its CIDP. This can be confirmed by the research which found that in all facilities, the SDGs were prioritized and implemented through various programs.

The lack of infrastructure hampered health for these vulnerable groups. Of particular concern was the lack of maternity wards in nine facilities and lack of laboratories in eight facilities. There was also a lack of mosquito nets for pregnant women in many facilities and lack of ambulance services in many facilities in Kisumu East and Seme Sub counties. Lack of maternity wards has resulted in 54% of women giving birth at home, due to the logistics of travelling to the referral hospital to give birth. This situation then exposes both mother and child to mortality in the event of complications. To accomplish
the County target of increasing hospital deliveries by 10%, the County must invest in maternity wards at all facilities. Lack of mosquito nets also exposes women to contracting malaria while pregnant thus endangering their health.

The County Government should equip the mental unit with staff, drugs, equipment and facilities to ensure that the treatment of these mentally ill patients is acceptable.

4.2.3 What strategies can CGK take to deliver on its functions

The CGK needs to invest in infrastructure especially to build laboratories, maternity wards, theatres, waiting bays, staff quarters in the facilities highlighted in this report.

The CGK needs to employ more doctors to improve the staff: patient ratio.

The CGK needs to ensure consistent supply of drugs especially in Kisumu Central.

4.2.4 What barriers obscure the realization of the right to health?

Sufficient budget to provide supplies needed in the facilities including staff and infrastructure.

Some cultural barriers which hinder access and practice of reproductive rights by women, as seen in the case of the JOOTRH where patients who had been inserted with a FP of their choice came back to remove it days later due to lack of consent from their spouses.

Another barrier is the lack of professionalism of staff who disrespected patients.

Kisumu County Integrated Development Plan, pg. 30
Strategies to promote health care for all
Sufficient budgetary allocation for infrastructure, staff, machines and supplies at all facilities.

Community outreach programs towards treatment of the mentally ill, reproductive health and non-communicable diseases.

Recommendations for relevant stakeholders in the health sector to address gaps affecting access to health care for all.

Training of staff to respect rights of patients and to give the patient relevant information regarding their diagnosis and treatment

Funding for infrastructure, machines and supplies including mosquito nets – donors can support the government in this areas

Community advocacy in areas of mental illness, cultural practices that hamper right to health like reproductive health.
5 ANNEXURES

5.1 Instruments

African Charter on Human and Peoples Rights

Committee on Economic, Social and Cultural Rights, General Comments

Convention on the Elimination of all forms of Discrimination Against Women (1979)
International Convention on Economic, Social and Cultural Rights


Sustainable Development Goals


Universal Declaration of Human Rights (1948)
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