FINAL DRAFT REPORT

BASELINE SURVEY ON GOVERNANCE AND MANAGEMENT OF HEALTH SECTOR

30th March 2015

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Abbreviations

ADS	Anglican Development Services
ADSMKE	Anglican Development Services Mount Kenya Region
AOP	Annual Operational Plan
CBO	Community Based Organization
CBO	Controller of Budget
CDF	Constituency Development Fund
CDH	County Director of Health
CDP	County Development Plan
CDPPO	County Development and Planning Officer
CFO	Chief Finance Officer
CHC	Community Health Committee
CHEW	Community Health Extension Worker
CHMT	County Health Management Team
CHP	Community Health Partners
CHW	Community Health Workers
CMF	Christian Mission Fellowship
Comm. Member	Community Member
EC	Executive Committee
FGD	Focus Group Discussions
FGDs	Focus Group Discussions
HCW	Health Care worker
HERAF	Health Rights Advocacy Forum
HFMC	Health Facility Management Committee
HIV	Human Immunodeficiency Virus
ICESCR	International Covenant on Economic, Social and Cultural Rights
IEC	Information education Communication
KI	Key Informant
KII	Key Informant Interviews
MCA	Members of the county assembly
MOH	Ministry of Health
NCCK	National Council of Churches of Kenya
NIDP	Narok Integrated Development Plan
OHCHR	Office of the High Commissioner for Human Rights
PLHIV	People living with HIV
PPA	Programme Partnership Agreement
PWD	People with Disabilities
RH	Reproductive Health
SCHMT	Sub County Health Management Team
SCMOH	Sub County Ministry of Health
SCPHN	Sub County Public Health Nurse
SCPHO	Sub County Public Health Officer
TRDP	Trans-Mara Rural Development Programme
UDHR	United Nations Universal Declaration of Human Rights
USIAD	United States Agency for International Development
WHO	World Health Organization

Acknowledgment

Health Rights Advocacy Forum (HERAF) wishes to acknowledge the technical and financial assistance extended to the organization by the Christian Aid in the whole process of undertaking this study. Our sincere gratitude goes to all Christian Aid technical staff that supported us in one way or another.

Special thanks to the county officials in Narok, Kiambu, Siaya and Isiolo counties where this study was undertaken for your support and participation. Without your support, this study would not have been successful. We are grateful to the people of Narok, Kiambu, Isiolo and Siaya counties in whose communities this study was undertaken, for their cooperation. Without your cooperation and participation, this study would not have been undertaken in your counties

We sincerely appreciate the following organizations: Narok Integrated Development Programme, Community Health Programme (CHP) and Trans-Mara Rural Development Programme (TRDP) all in Narok County; Anglican Development Services (ADS in Siaya County; Anglican Development Services Mount Kenya Region (ADSMKE) in Isiolo and; National Council of Churches of Kenya (NCCK) in Kiambu County whose dedication contributed to making this study a success. Our appreciation goes to all staff of these organizations without whose contribution; this initiative would not have been possible.

We acknowledge the research consultant Dr. Margaret Makumi for her invaluable technical support to the whole process. Your contributions in conceptualizing and designing the baseline survey, data collection, data analysis and report writing are highly appreciated.

Finally, a special appreciation to all HERAF staff who in one way or another supported this study, keep up with the good spirit.

Executive Summary

Introduction

Health Sector and Health Systems

The descriptions of the terms health sector and health systems often used inter changeably, are well articulated by the World Health Organization (WHO). The health sector is made up of the people, institutions and resources, arranged together in accordance with established policies, whose primary purpose is to promote, restore and maintain health while health systems are the enablers for maximizing health.

Health Rights

The right to health is the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. It was first recognized as a human right in Article 25 (1) of Universal Declaration of Human Rights (UDHR). It was recognized again in the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR) in Article 12 (1). In Kenya, the right to health is recognized in Kenya's Constitution of 2010 in Article 43(b). The right to health does not mean the right to be healthy but must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions in order to achieve the highest attainable standard of health.

Governance in Health Sector

Governance in health is a cross-cutting theme, intimately connected with issues surrounding accountability. In the context of health systems strengthening, it is one of six building blocks that contribute to the strengthening of health systems. Governance in building a health system involve ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system design and accountability.

Baseline Objectives

The aim of the baseline survey is to provide the health governance project with in-depth understanding of citizen's engagement in governance of health sector in Narok, Isiolo, Kiambu, and Siaya counties. The survey will also establish the project's benchmarks for comparing and impact measurement at the end of the project.

Methodology

The baseline survey targeted community members, community health workers, religious leaders, health care workers, community health committee members, health facility management committee members, county health management team members, county government officials, sub-county health management team members and members of the county assemblies.

A convenience sampling method was used to select those who responded to the questionnaire, key informant interviews (KII) and participated in the focus group discussions (FGDs). Details of who was selected to participate in the study are provided in appendix [1].

Data collection methods used in the review included questionnaire, Key informant interviews (KII), focus group discussions (FGDs) and review of literature and documents related to health rights and governance in the health sector.

Recorded notes from focus group discussions (FGDs) and key informant interviews were transcribed and the transcripts developed into codes to identify important substantive themes for interpretation and analysis.

Key Findings

Health Rights

Key informants and focus group discussion participants comprising duty bearers and right holders respectively could not define right to health comprehensively. As a result, they cannot carry out their mandate of protecting and promoting the right to health and ensuring accountability respectively.

Over 80% of respondents in all categories responding to the questionnaire reported they are aware of consumers of health care services, health rights. However, all categories of respondents could not comprehensively articulate at least three health rights entitled to the consumers of health services. On health rights of healthcare workers, about 60% of respondents in all reported they are aware they have health rights. However, articulation of at least three health rights of healthcare workers revealed that the health rights referred to by respondents were in relation to their work as health care providers but not their entitlement to health as human beings.

All respondents in all categories except one FGD in Kiambu County reported they are aware Kenya's constitution guarantees the right to the highest attainable standards of health which includes the right to health care services, including reproductive health rights.

Community members' involvement in decision making process in county health structures

Health Committees

The health committee that was known to most respondents was community health committee at 62.9 % followed by the facility management committee at 33.9% and county health management team at 3.2%
Apart from the community members (56.8%) and religious key informant, most of all other categories of respondents including FGDs participants reported that health committee members are selected by the community through chief's Barraza.

On training of health committee members on roles and responsibilities, All CHMT members reported they had been trained followed by CHC at 66.7% while most of SCHMT, 90 % reported they had not been trained followed by HFMC at 45.8% It was noted that most of the training are conducted by CSOs
It is worth noting that new policy guidelines/rules for selecting HFMC in line with the 2010 constitution are not in place. However, counties continue to use guidelines issued by the national government prior to devolution of health sector. Based on the old guidelines, women representation in the HFMC among special groups was reported by most respondents at 26.1%. Representation of people with disabilities was the least mentioned at 15.3%).

While over 80% of all other categories of respondents reported that they are aware of the roles, functions and responsibilities of the HFMC, only 67.7% of community members reported they know. KII and FGDs participants had a general idea of what the roles, functions and responsibilities of HFMC are. On whether the HFMC report back to the community, the proportion of community members who reported that the committee report back was 50% compared to over 50% among all other categories of respondents. The chief's Barraza was reported by most respondents (26.5% as the mechanism used for reporting back while the media is never used. The FGDs participants reported that the committee members do not report back. A participant said *"No reporting back. We see them working but they don't report back to the community"*

Transparency and Accountability at Dispensary/Health Centre Level

Community members are hardly involved in the management of the health facilities nearest to them. 36.6% of community members reported that the facility has not held a meeting involving the public to review performance and progress of their facility. This was collaborated by FGDs participants where

one of them said "*We should be involved but they are not involving us in running the facility or discussing performance and progress. We see the progress when we come to facility for health care services e.g. New tank, New staff etc.*

The customer service charter has been seen or heard by over 65% of the respondents including FGDs participants, is displayed in their facilities but partially adhered to.
About 93% and 88% of community members and community health workers respectively reported that facilities do not collect complaints from clients compared to most of the respondents in the other categories. The suggestion box was reported as the mechanism mostly used for collecting complaints at 46.9%

Community involvement in Planning and Budgeting

About 80% of community members reported that community members are not involved in planning and budgeting for their facility every financial year compared to most of the respondents in the other categories. However, most of the respondents including FGDs and KII participants are aware that community members should be involved in planning and budgeting for their respective facilities.

County Planning and Budgeting

Except for the CHMTs, SCHMTs and healthcare workers, majority of the respondents in the other categories reported they have never seen or heard about the county development plans.

On whether there are reasons given by county officials while preparing the budget, except for CHMT who reported at 100% that there are reasons give, majority of respondents in all other categories reported there are no reasons given or were not aware of the same.

On whether the county governments allocated enough money to the health sector, there was consensus among all respondents that that they don't. However, majority of respondents in all categories except CHMT reported that they were not aware they can influence/engage with the county government to allocate more money to their community health priority areas.

On gender, there were more men than women with secondary and above level of education, aware of health rights and governance issues.

Conclusion

- The study has revealed gaps in articulation of health rights by duty bearers and right holders that requires to be addressed if they are to effectively carry out their respective mandates of protecting, promoting and ensuring accountability in the health sector governance and management.
- The study has also revealed gaps in the involvement of community members in decision making process in county health structures. In line with Kenya's 2010 constitution and in the spirit of devolution, for the community to be involved, there is need to enhance their skills and knowledge thus empowering them to demand for their rights for meaningful engagement in decision making process at the various levels of county health sector .

Recommendations

- The duty bearers and right holders capacity needs to be build/enhanced to enable them carry out their mandate of protecting and promoting the right to health and ensuring accountability respectively.
- There is also the need to build/enhance the capacity of the citizens in the four counties to facilitate them effectively participate in all aspects of governance of the health sector in their respective regions.

1.0 Introduction

1.1 Background

The descriptions of the terms health sector and health systems often used inter changeably, are well articulated by the World Health Organization (WHO) [1]. The health sector is made up of the people, institutions and resources, arranged together in accordance with established policies, whose primary purpose is to promote, restore and maintain health. It includes government ministries and departments, hospitals and other health services, health insurance schemes, voluntary and private organizations in health, as well as the pharmaceutical industry and drug wholesale companies [2].

Health systems are the enablers for maximizing health [3]. Description of health systems is similar to that of health sector. It consists of all the organizations, institutions, resources and people whose primary purpose is to improve health. This includes efforts to influence determinants of health as well as more direct health-improvement activities. The health system delivers preventive, primitive, curative and rehabilitative interventions through a combination of public health actions and the pyramid of health care facilities that deliver personal health care — by both State and non-State actors. To deliver, a health system needs workers, facilities, money, information, medicines and technologies, communications, transport as well as overall leadership and direction [1]. It also needs to put people at the center, while providing services that are responsive and financially affordable.

WHO also describes health systems in terms of six building blocks[1]. The building blocks namely (i) service delivery (ii) health workforce (iii) health information systems (iv) access to essential medicines (v) financing and (vi) leadership/governance contribute to strengthening of health systems in different ways.

Health Rights

The right to health was first recognized as a human right in Article 25 (1) of universal declaration of health rights (UDHR) as a component of adequate living standards [4]. The right to health was again recognized as a human right in the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR) [5.] Article 12 (1) of ICESCR establishes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. In Kenya, the right to health is recognized in the constitution of 2010. Article 43(b) of the constitution state that every person has the right to the highest attainable standards of health which includes the right to health care services, including reproductive health rights [6.]

The right to health does not mean the right to be healthy [7]. Good health is influenced by several factors that are outside the direct control of States, such as an individual's biological make-up, socio-economic conditions and adoption of unhealthy or risky lifestyles. The right to health must therefore be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions in order to achieve the highest attainable standard of health.

Right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights [7]. They include the rights to human dignity, privacy among others and they address integral components of the right to health.

The right to health is an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health [7.] It contains four elements which include availability, accessibility, acceptability and quality.

Right to health also contains both freedoms and entitlements. The freedoms include right to be free from non-consensual medical treatment, such as medical experiments and research or forced sterilization, and to be free from torture and other cruel, inhuman or degrading treatment or punishment. The entitlements include 1) Right to maternal, child and reproductive health 2) Right to healthy natural and workplace environments 3) Right to prevention, treatment and control of diseases and 4) Right to health facilities, goods and services.

Governance

The World Bank defines governance as the traditions and institutions by which authority in a country is exercised for the common good includes the process by which those in authority are selected, monitored and replaced, the capacity of the government to effectively manage its resources and implement sound policies, and the respect of citizens and the state for the institutions that govern economic and social interactions among them [8].

Governance in health is a cross-cutting theme, intimately connected with issues surrounding accountability [1]. In the context of health systems strengthening, it is one of six building blocks that contribute to the strengthening of health systems. Governance in building a health system involve ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system design and accountability.

The need for greater accountability arises both from increased funding and a growing demand to demonstrate results [9]. As an intrinsic aspect of governance accountability concerns the management of relationships between various stakeholders in health, including individuals, households, communities, firms, governments, nongovernmental organizations, private firms and other entities that have the responsibility to finance, monitor, deliver and use health services. In a nutshell, accountability can be defined as the result of the process which ensures that health actors take responsibility of what they are obliged to do and are made answerable for their actions.

2.0. Methodology

2.1. Assessment Target Area

The baseline survey was conducted in Narok, Isiolo, Kiambu and Siaya counties which are focus counties of the Programme Partnership Agreement (PPA)-Health supported by Christian Aid.

2.2 Objectives of the Baseline Survey

The aim of the baseline survey is to provide the health governance project with in-depth understanding of citizen's engagement in governance of health sector in Narok, Isiolo, Kiambu, and Siaya counties. The survey will also establish the project's benchmarks for comparing and impact measurement at the end of the project.

2.2.1 Scope of Work

1) To assess levels of human rights and the right to health awareness among community members, health care workers, county health management team members, county government officials, sub-county health management team members and members of the county assembles.
2) To assess whether community members are involved in decision making processes in county health structures.
3) To gauge facility management committee members knowledge of health policy framework and their roles and responsibilities.
4) To assess whether community members hold facility management committee members, health care workers and county government officials accountable.

2.3. Target population

The baseline survey targeted community members, community health workers, religious leaders, health care workers, community health committee members, health facility management committee members, county health management team members, county government officials, sub-county health management team members and members of the county assemblies.

2.4. Sampling Process

A convenience sampling method was used to select those who responded to the questionnaire, key informant interviews (KII) and participated in the focus group discussions (FGDs). Details of who was selected to participate in the study are provided in appendix[1].

2.5. Data Collection Methods

Data collection methods used to gather information for the baseline study included a questionnaire, key informant interviews and focus group discussions.

- Questionnaire

The questionnaire was used to obtain information on governance and management of health sector from community members, community health workers, community health committee members facility in charges, healthcare workers, health facility management committee members, sub-county health

management team (SCMOH/SCPHO, SCPHN), and county health management team (Director of Preventive & Promotive; and Community Strategy contact person).

-Key Informant Interviews (KII)

Key informant interviews were conducted with religious leaders, a representative of County Treasury, County Development and Planning Officer CDPPO), County Director of Health (CDH), County Assembly i.e. chairs of Committee on Budgets and Health Budget Committee and the Members of the County Assembly representing the wards within which the selected facilities are situated.

- Focus Group Discussions (FGD)

FGDs were conducted to compliment information on governance obtained using the questionnaire and KII interviews. Participants comprised community members who had not been interviewed using the questionnaire or KII and had no leadership roles in the community.

2.6. Data Quality Assurance

To ensure that high quality standard was maintained and that the data obtained from the questionnaire, key informant interviews and focus group discussions meet data quality standards, the following minimum measures were instituted:

- One day training was conducted for all the research assistants by the same facilitators. Role play was one of the methods of training used to ensure research assistants clearly understood the data collection tools and how they were to be applied in the field.
- The three data collection tools were made simple and easy to understand by research assistants. Support was provided to the research assistants on site by the HERAF research team who accompanied them to the field.
- Submitted completed questionnaires and key informant interviews were checked on the spot and verified by the HERAF team before letting go the respondents. This exercise ensured that respondents could clarify or make corrections where necessary.
- After data entry, data cleaning and validation were carried out to identify errors and inconsistencies for correction.

2.7. Data Analysis

The data from the questionnaire was analyzed using SPSS Version 13.0. Basic descriptive statistics in the form of tables were generated for key indicators.

Recorded notes from key informant interviews and focus group discussions (FGDs) were developed into codes to identify themes for interpretation and analysis. Reports generated from the analysis have been synthesized and harmonized for the main report. The qualitative results were used to clarify and provide in-depth meaning of the quantitative data generated.

2.8. Limitations of the Assessment

The following were some of the limitations of the assessment:

- Members of the county assembly MCAs) were in recess. This made it difficult for the research team to reach some of them who were key respondents.
- Some county government staff members were not reached. Research team made several attempts through their cell phones but the calls were either not answered or they could not be reached and when reached said they are not available
- Some facilities had two healthcare workers and on the day of interview, only one staff was available and therefore interviewed as in charge of the facility

- There was tension in Trans Mara between the Kisii and Maasai and therefore it was difficult for research assistants to get two and one facility committee and community health committee members respectively.

3.0. Findings

3.1. Human rights and the right to health awareness

3.1.1. Definition of Health Rights

Key informants (Religious leaders, County Director for Health, County Development and Planning Officer, County Chief Finance Officer, County Assembly chairs of budget and health budget committees and Members of the County Assembly from the wards within which the facilities selected for the study are situated) and FGDs participants (community members with no leadership role) were asked to define health rights. Article 12.1 of ICSCR defines right to health as the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Table 1 below depicts a summary of the responses gathered from the respondents but none defines the right to health comprehensively.

Table 1: Definition of right to health by KII and FGD respondents

Definition of right to health	
Key Informants Interviews (KII)	**Focus Group Discussions**
• To come to health center when you are sick • A patient to get all the drugs at the facility at all times when required • A person to stay well, be treated and the environment should be good • To have a health facility • Right to access healthcare services • Those liberty given to people so that they can take care of their health and others • Access to affordable health and nutrition and environmental health. • Ability to seek immediate health care • Right to education on the health rights • Right to access free medical and other constitutional provisions on health by state • Prevention and treatment of diseases	• The ability to access health care • Access to medical care without any restrictions or corrupt deals • Medical care being brought closer to the community • Good and nutritious foods • Getting treatment at the right time. • How you should be handled when you go to the hospital. • Right to get information in time. • Every individual should be treated irrespective of the group they represent • Services that a client should receive from the medical Center

Key informants comprised of community gate keepers, political leaders and county government officials who as duty bearers could contribute significantly to protection and promotion of right to health in their counties. On the other hand, community members participating in the FGDs are part of right holders who should hold duty bearers accountable. The gap in describing the right to health therefore needs to be addressed to facilitate the duty bearers and the right holders carry out their mandate protecting and promoting the right to health and ensuring accountability respectively.

The KI respondents were also asked to name at least three health rights. Analysis of information gathered showed that most responses were under the right to health facilities, goods and services.

Responses related to other entitlements contained in the right to health were few and there were no responses to rights to freedom associated with the health rights. This is an indication of knowledge gap that needs to be addressed to enable the duty bearers protect and promote the human right to health.

3.1.2. Health rights of consumers of healthcare services

Respondents of the questionnaire (community members; community health workers; community health committee; health facility management committee; health facility in charges, health care workers, sub-county health management team and the county health management team) were asked whether they are aware of consumers of healthcare services, health rights. As depicted in Table 2 below, HFMC members, health facility in charges, health care workers (HCW), sub county health management team (SCHMT) and the county health management team (CHMT) members reported 100% they are aware that consumers of health services have health rights. Out of the 72 and 24 community members and community health care workers interviewed, 60 (83.3%) and 23(95.8%) respectively reported they are aware of consumers of healthcare services, health rights. Members of community health committees (CHC) who reported they are aware of consumers of healthcare services health rights were 21 (87.5%) out of 24 interviewed.

Table 2: Distribution of respondents' responses on awareness of consumers of health services health rights by County

County	Respondents															
	Comm. member		CHWs		CHC		HFMC		Facility in charge		HCW		SCHMT		CHMT	
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Narok	29	7	12	0	9	3	12	0	6	0	5	0	4	0	2	0
Kiambu	7	5	3	1	4	0	4	0	2	0	1	0	4	0	1	0
Isiolo	12	0	4	0	4	0	4	0	2	0	1	0	1	0	2	0
Siaya	12	0	4	0	4	0	4	0	2	0	2	0	2	0	2	0
Total	60	12	23	1	21	3	24	0	12	0	9	0	11	0	7	0

Respondents who reported that they are aware of consumers of health services, health rights were asked to name at least three health rights that they know.

Analysis of information gathered from the respondents on stating at least three health rights showed that most of the responses were on right to health facilities, goods and services. These findings tally with the key informant findings on their responses regarding stating three health rights. Right to maternal, child and reproductive health had the least responses followed by the right to prevention, treatment and control of diseases and ; the right to right to healthy natural and workplace environments. Among the freedom rights associated with health eights, there was no response on right to be free from torture and other cruel, inhuman or degrading treatment or punishment and only one response on the right to be free from non-consensual medical treatment. Human rights to privacy and confidentiality were reported in all counties. The findings indicate that knowledge on rights to health and freedoms in all counties is not sufficient and requires to be addressed to enable the citizens in the said counties protect, promote and demand for them.

- Awareness on whether health facilities guarantee health rights to consumers of healthcare services

The survey sought to establish whether the health facilities nearest to the respondents guaranteed the consumers of healthcare services the reported health rights. As shown in Table 3 below, analyses of information collected indicate that HFMC, health facility in charges, SCHMT and CHMT interviewed in

all counties, reported 100% that consumers of health care services are either guaranteed their health rights by the facilities nearest to them all the time or sometimes.

The percentage of total number of community members and community health workers who reported the consumers of health care services are guaranteed their health rights all the time or sometimes was 58 (96.7%) and 20 (87%) out of 60 community members and 23 CHWs interviewed respectively. Among the health care workers 8(88.8%)) respondents out of 9 interviewed reported that consumers of health care services are guaranteed their health rights all the time or sometimes.

Although 87% and above of respondents among all categories in the 4 counties reported consumers of healthcare services are guaranteed health rights all the time or sometimes, their knowledge on health rights is insufficient as noted above. Knowledge of all categories of respondents on health rights needs to be improved in the 4 counties thus enhancing their understanding on whether the consumers of health services are guaranteed health rights all the time, sometimes or not at all by the health facilities nearest to them.

Table 3: Distribution of respondents' responses on whether health facilities guarantee consumers of health services health rights by County

County	**Respondents**																							
	Comm. member			**CHW**			**CHC**			**HFMC**			**Facility in charge**			**HCW**			**SCHMT**			**CHMT**		
	Y	ST	N	Y	ST	N	Y	ST	N	Y	ST	N	Y	ST	N	Y	ST	N	Y	ST	N	Y	ST	N
Narok	10	17	2	5	5	2	6	4	2	10	2	0	6	0	0	4	0	1	1	3	0	2	0	0
Kiambu	4	3	0	0	2	1	3	1	0	1	3	0	1	1	0	0	1	0	1	2	0	1	0	0
Isiolo	10	2	0	1	3	0	4	0	0	3	1	0	2	0	0	1	0	0	1	0	0	2	0	0
Siaya	8	4	0	1	3	0	3	1	0	0	0	0	0	2	0	1	1	0	1	1	0	1	1	0
Total	**32**	**26**	**2**	**7**	**13**	**3**	**16**	**6**	**2**	**5**	**6**	**0**	**9**	**3**	**0**	**6**	**2**	**1**	**4**	**6**	**0**	**6**	**1**	**0**

Information was also gathered from key informants on whether health rights of consumers of health care services are guaranteed by health facilities nearest to them. Most respondents reported that the rights of consumers of health care services are poorly met. A member of a county assembly had this to say: *"The extent to which the health system guarantees health rights to consumers is poor. For example, currently in my ward, there are 5 government health facilities but only one is functional. In addition, the facility only has one healthcare worker yet the population is high-about 100,000. Also, there road network is poor further impacting negatively to accessing the facility. There is no electricity which may affect provision of quality health care services."*
Another MCA said*: "Basic health rights are not even met in my ward because there are no government facilities. There is only one community facility supported by Christian Mission Fellowship (CMF). There have been no HCWs and only recently the county posted two clinical officers. There are no drugs, equipment and the alternative a private facility is not affordable".*

Religious leader had this to say: *"Poor. Consumers are poorly attended to, sometimes hospital is closed and there are no enough health care workers"*

A county development and planning officer said*: "The extent to which health system guarantees health rights to consumers is low given that majority of the consumers are in the rural areas where distances to health facilities is more than 5km. This compounds access to public facilities and since the nearest facility might be private affordability is compromised."*

The finding from KII that there is poor guaranteeing of health rights to the consumers of health care services differs from the finding from questionnaire interviews that showed over 87% of respondents in all categories reporting they are guaranteed their health rights. The in-depth interrogation applied in KII is likely to have brought to the fore the real issues compared to questionnaire interviews where the

answer is either a no or yes without probing. Gaps therefore exist calling for creation of awareness on human rights to health in all counties.

3.1.3. Health rights of healthcare workers

Respondents of the questionnaire (Community members; community health workers; community health committee; health facility management committee; health facility in charges, health care workers, sub-county health management team and the county health management team) were asked whether they are aware of healthcare workers health rights. The HCW, CHMT, SCHMT interviewed said they are aware of healthcare workers health rights.

Among the health facility in charges, all except one in Narok County reported they are aware of the health rights of health care workers. Community members and community health workers who reported they are aware of the health care workers health rights were 43 (59.7%) and 23 (95.8%) out of 72 and 24 interviewed respectively. Among the community health committee and health facility management committee members 19 (79.2%) and 22 (92.7%) out of 24 interviewed for each category said they are aware of the health care workers health rights.

The category of respondents with the lowest proportion of respondents aware of the health care workers is community members followed by community health committee members. There is therefore need to educate communities not only on their rights and responsibilities but also on the rights of the health care workers.

Table 4: Distribution of respondents' responses on awareness of healthcare workers health rights by County

County	Respondents															
	Comm. member		CHWs		CHC		HFMC		Facility in charge		HCW		SCHMT		CHMT	
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Narok	20	16	8	4	8	4	11	1	5	1	5	0	3	0	2	0
Kiambu	6	6	4	0	3	1	4	0	2	0	1	0	3	0	1	0
Isiolo	7	5	4	0	4	0	3	1	2	0	1	0	2	0	2	0
Siaya	10	2	4	0	4	0	4	0	2	0	2	0	2	0	2	0
Total	43	29	23	1	19	5	22	2	11	1	9	0	10	0	7	0

Respondents who reported that they are aware of healthcare workers health rights were asked to name at least three health rights that they know. Analysis of information gathered showed that most of the responses were on right to healthy natural and workplace environments. This finding indicates that the responses given are in relation to the work place of the healthcare workers and not as consumers of health care services. The right to human dignity-respect was also frequently reported as right for the health care workers but could also be interpreted to mean the respect that the health care workers need to be accorded at work place. These findings generally indicate that the respondents though they said they are aware of the health rights of healthcare workers as reported above, their understanding of those rights is insufficient. This gap in knowledge need to be addressed to enable the respondents recognizes healthcare workers as human beings with human rights to health and not just work's related rights.

-Awareness on whether health facilities guarantee health rights to healthcare workers

The survey further sought to establish whether the health facilities nearest to the respondents guaranteed the healthcare workers the reported health rights. As shown in Table 5 below, analyses of

information collected indicate that among the HFMC, health facility in charges, healthcare workers, CHMT and SCHMT who responded 100% said healthcare workers are either guaranteed their health rights all the time or sometimes by the health facilities nearest to them.

Among the community members and community health workers, 35 (83.3%) and 17 (85%) out of 42 and 20 interviewed reported that healthcare workers are guaranteed their health rights either all the time or sometimes. Community health committee members who said healthcare workers are either guaranteed health rights by the facilities nearest to them all the time all sometimes were 21 (90.3%) out of 23.

In spite of these findings, it is important to note that the health rights stated by the respondents were in relation to the healthcare work place and not their human rights to health as observed above. As noted above, there is therefore need to address the knowledge gap to enable the respondents recognize healthcare workers as human beings with human rights to health and not just work-related rights.

Table 5: : Distribution of respondents' responses on whether health facilities guarantee healthcare workers health rights by County

County	**Respondents**																							
	Comm. member			**CHW**			**CHC**			**HFMC**			**Facility in charge**			**HCW**			**SCHMT**			**CHMT**		
	Y	ST	N	Y	ST	N	Y	ST	N	Y	ST	N	Y	ST	N	Y	ST	N	Y	ST	N	Y	ST	N
Narok	8	8	4	2	5	1	7	5	0	6	5	0	3	1	0	3	1	0	1	2	0	0	2	0
Kiambu	3	1	2	0	2	2	1	1	1	3	1	0	1	1	0	0	1	0	0	2	0	0	1	0
Isiolo	0	5	1	1	3	0	1	3	0	2	2	0	1	0	0	1	0	0	1	0	0	2	0	0
Siaya	7	3	0	2	2	0	2	1	1	4	0	0	0	2	0	1	1	0	2	0	0	0	1	0
Total	**18**	**17**	**7**	**5**	**12**	**3**	**11**	**10**	**2**	**15**	**8**	**0**	**5**	**4**	**0**	**5**	**3**	**0**	**4**	**4**	**0**	**2**	**4**	**0**

The survey gathered information from key informants on whether health rights of healthcare workers are guaranteed by health facilities nearest to them. A respondent had this to say: *"Extent to which the health system guarantees healthcare workers' rights is very low. This is because there is inadequate housing for them, poor salary which is not paid on time."*
Another respondent said: *"Extent to which the health system guarantees healthcare workers' rights is also poor. There is inadequate housing for the HCWs e.g. the HCWs in my ward lives far from the facility and due to this they arrive late at the facility and leave early. The HCWs are also overworked due to staff shortages."*
A religious leader had this to say: *"The rights of healthcare workers are not guaranteed because, tools of trade are sometimes lacking"*

Responses gathered from KI are also in relation to the health care provision carried out by the healthcare workers but not right to health rights entitled to them as human beings. This gap needs to be addressed through awareness creation in all counties.

3.1.4. Provision of health right in Kenya's Constitution

The survey collected data to determine whether the respondents are aware that Kenya's constitution guarantees the right to the highest attainable standards of health which includes the right to health care services, including reproductive health rights. Data collected was analyzed and results depicted in Table 11 below.

All health facility in charges, healthcare workers, CHMT interviewed said they are aware Kenya's constitution guarantees the right to the highest attainable standards of health which includes the right to

health care services, including reproductive health rights while among the SCHMT there was one respondent (9.1%) who was not aware in Kiambu County.

Among the community members and community health workers, 52 (72.2%) and 21 (87.5%) respondents out of 72 and 23 interviewed said they are aware that Kenya's constitution guarantees the right to health including reproductive health respectively. Community health committee members and health facility management committee members who reported they are aware Kenya's constitution guarantees health rights including reproductive health were 18 (75%) and 22 (91.7%) out of 24 interviewed per category of respondents.

Community members are lest aware that Kenya's constitution guarantees health rights including reproductive health followed by the community health committee members indicating there is need to sensitize them on the health rights provisions in the constitution.

Table 6: Distribution of respondents' responses on whether the respondents are aware that Kenya's constitution guarantees the right to health including reproductive health rights by County

County	**Respondents**															
	Comm. member		**CHW**		**CHC**		**HFMC**		**Facility in charge**		**HCW**		**SCHMT**		**CHMT**	
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Narok	28	8	10	2	9	3	11	1	6	0	5	0	4	0	2	0
Kiambu	8	4	3	1	3	1	3	1	2	0	1	0	3	1	1	0
Isiolo	8	4	4	0	3	1	4	0	2	0	1	0	1	0	2	0
Siaya	8	4	4	0	3	1	4	0	2	0	2	0	2	0	2	0
Total	**52**	**20**	**21**	**3**	**18**	**6**	**22**	**2**	**12**	**0**	**9**	**0**	**10**	**1**	**7**	**0**

Participants of focus group discussions were asked to name Kenyan documents that state what the health rights are. Responses from FGDs with the exception of one FGD in Kiambu County included the constitution of Kenya as one of the documents that state what health rights are among others such as IEC materials, charts displayed in health facilities, charts displayed in police stations. The Kiambu County FGD that did not mention the constitution mentioned only one document called "an Act of parliament". This finding tallies with the finding above that there were some respondents of questionnaire interviews that were not aware that the constitution of Kenya has provisions on health rights. This calls for sensitization of community members on the right to health provisions contained in the constitution.

3.2. Community members' involvement in decision making process in county health structures

3.2.1. Health Committees

-Awareness on Health Committees Representation in the Community

Community members and community health workers were asked whether they are aware of different health committees represented in their community. Table 7 below shows that 39 (55.7%) out of 70 community members interviewed reported that they are aware of different committees represented in their community while 31 (44.3%) said they are not aware. Among the community health workers, 22 (91.7%) reported they are aware.

Since 44.3% of community members were not aware of the different health committees represented in their community, there is need to establish mechanization for conducting community sensitizations on health committees' representation in the community.

Table 7: Distribution of respondents' responses on whether they are aware of different health committees represented in their community by County

County	Respondents				Total
	Community Members		CHWs		
	Yes	No	Yes	No	
Narok	18	17	10	2	47
Siaya	4	8	4	0	16
Kiambu	8	4	4	0	16
Isiolo	9	2	4	0	15
Total	39	31	22	2	94

Community members and community health workers who said they are aware of health committees represented in their community were asked to state relevant health committees represented in their community. As shown in Table 8 below, the community health committee was known to 39 (62.9 %) out of 62 respondents. The facility management committee was reported by 21 (33.9%) out of 62 respondents while 2 (3.2%) respondents reported county health committee as known to them.

The community health committee is a health governance structure that oversees the functions of the community health workers was probably known to most respondents because it is based at the community level. None the less, there is need to sensitize the community members and the community health workers on relevant health committees represented in their community.

Table 8: Distribution of respondents' responses on relevant health committees represented in their community by County

County	Respondent	Health Committee			Total
		Community Health Committee	Facility Management Committee	County Health Committee	
Narok	Community Member	13	4	1	18
	CHW	8	2	0	10
Siaya	Community Member	2	2	0	4
	CHW	1	3	0	4
Kiambu	Community Member	4	3	1	8
	CHW	2	2	0	4
Isiolo	Community Member	7	3	0	10
	CHW	2	2	0	4
Total		39	21	2	62

-Existence of health facility management committees

Data collected on health committees from the community members and community health workers was analyzed to determine whether there is a health facility management committee at the health facility nearest to them. About 83% and 96% community members and community health workers interviewed said there is a facility management committee in the facility nearest to them respectively.

Data was gathered through FGDs to determine whether there is a health facility management committee at the health facility nearest to them. It emerged from the discussions that most of the participants were aware a health committee exists at the facilities and could even give names of

members. A participant said "*There is a health committee and I know the Chairman*". Another one reported that there is a committee and gave names of several members of the committee.

-Health Facility Commette Membership

Table 9 below, depicts responses from respondents on whether health facility management committee members are elected /appointed/ selected by their community. All healthcare workers, SCHMT and CHMT interviewed said the committee members are elected/appointed/selected by the community.

Among the community members, 21 (56.8%) out of 37 interviewed reported that the committee members are elected/appointed/selected by the community while a total of 16 (43.2%) said they are not elected/appointed/selected by the community or did not know. Over 90% of CHWs, CHC, HFMC and health facility in charges reported the committee members are elected/appointed/selected by the community.

The community members were the least informed on whether health facility management committees members are elected/appointed/selected by the community. There is therefore the need to sensitize them on the process and procedures of electing/appointing/selecting health committees as they are expected to be engaged in the process of electing their representatives to the committees.

Table 9: Distribution of respondents' responses on whether health facility management committee members are elected /appointed/ selected by their community by County

County	Respondents																							
	Community Members			CHW			CHC			HFMC			Facility In charges			HCW			SCHMT			CHMT		
	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK
Narok	11	1	6	10	0	0	12	0	0	11	1	0	5	0	1	4	0	0	3	0	0	2	0	0
Kiambu	5	0	2	4	0	0	4	0	0	4	0	0	2	0	0	1	0	0	3	0	0	1	0	0
Isiolo	4	0	3	4	0	0	4	0	0	4	0	0	2	0	0	1	0	0	2	0	0	2	0	0
Siaya	1	1	3	2	1	0	3	1	0	4	0	0	2	0	0	2	0	0	2	0	0	2	0	0
Total	21	2	14	20	1	0	29	1	0	23	1	0	11	0	1	8	0	0	10	0	0	7	0	0

It was also clear from the FGDs that health facility management committee members are elected by the community. On the contrary, they revealed that sometimes committee members are selected by the chief. One of the participants had this to say *"Selection was done by the chief during a Barraza meeting".* Another one said *"The sub chief appointed six representatives to go and represent the community in the committee meeting".*

Among the key informants, most of the religious leaders said they don't know how they are selected. There were also those who said they know they are selected by community but do not know how they were appointed. For example, a participant said "*They are elected but I don't know the criteria".* Another one said *"I guess through appointment having just heard from people"*
The findings from FGDs and religious leaders KII confirm the need to sensitize the community members including religious leaders on how the health committee members are elected.

-Training on Roles and Responsibilities

Respondents who said they are health committee members were asked whether they have ever been trained in order to know their roles and responsibilities**.** As shown in table 10 below, all CHMT members in all counties said they had been trained followed by CHC at 16 (66.7%) out of 24 interviewed. Among SCHMT, 9 (90%) out of 10 reported they have not been trained. Followed by HFMC at 11 (45. 8%) out of 24 interviewed. These findings indicate that individuals are given appointments but they are not given the necessary capacity to perform such tasks. Denial of such capacity is a violation of human

rights of such committee members. There is therefore the need to conduct training for the health committee members on their roles and responsibilities.

Table 10: Distribution of category of respondents' responses on special groups that have a member in the health facility management committee by County

County	Respondents							
	CHC		HFMC		SCHMT		CHMT	
	Yes	No	Yes	No	Yes	No	Yes	No
Narok	8	4	4	8	0	3	2	0
Kiambu	1	3	2	2	1	2	1	0
Isiolo	4	0	4	0	0	2	2	0
Siaya	3	1	3	1	0	2	2	0
Total	16	8	13	11	1	9	7	0

The health committee members who said they had been trained on their roles and responsibilities were asked to state who trained them. The responses are as depicted in Table 11 below that shows there are many organizations and institutions that support training of health committee members on their roles and responsibilities. The Table indicates that most of the trainings are conducted by civil society organizations, religious institutions, United Nations Agencies, development agencies such as USIAD, APHIA Plus. Christian aid partners in each of these counties were found to have played a great role in these trainings. They include Christian Health Partners, TRDP and NIDP in Narok county; Anglican Development Services, Mount Kenya Region in Isiolo county. Even where MOH has organized trainings it was found that this is done in collaboration with civil society and religious organizations. Other organizations that were mentioned as having provided some trainings include – Managements Sciences for Health, Kenya Episcopal Conference, World Vision, Plan International – Kenya, Kenya Red-cross Society, Food for the Hungry, Kenya and Funzo Kenya. There is need to conduct advocacy towards ownership of the same by the counties now that health is a function that almost wholly belongs to the county.

3.2.2. Policy guidelines for selecting health committee members, their Roles and responsibilities

-Policy guidelines for selecting health committee members

The survey intended to determine whether the community members, community health workers, CHC members, HFMC members, facility in charges, healthcare workers, SCHMT and CHMT are aware of any policy guidelines/rules that should be followed during the election/appointment of health facility management committee members. This question was however not applied to the respondents because from the onset, the survey team was informed by county officials that new policy guidelines/rules aligned to the constitution are yet to be in place. The counties are continuing to use the old guidelines issued by the national government prior to devolution of health sector. The guidelines have gaps and need to be revised and adopted by each county to guide in appointment and operations of the health committees.

However, based on the old national guidelines, principles and values of the constitution the survey sought to understand the representation of various categories and especially the marginalized in the committees. The respondents were asked to state the special groups that have a member in the health facility management committee.

Information collected was analyzed and as shown in Table 10 below, representation of women as a special group was reported by most respondent at 123 (26.1%) out of the 470 who reported special group representation followed by representation of youth at 110 (23.4%) and the elderly at t 92 (19.6%).

Representation of people living with disabilities was the least reported at 72 (15.3%) followed by people living with HIV at 73 (15.5%). From the analysis, sensitization of all category of respondents except the CHMT on the need for special groups representation in the health committees as provided for in the policy/guidelines is required in the four counties.

Table 11: Distribution of category of respondents' responses on special groups that have a member in the health facility management committee by County

County	Women	Youth	PLHIV	PWD	Elderly	Total
Narok	54	49	37	33	40	213
Kiambu	21	21	12	8	15	77
Isiolo	25	24	11	17	20	97
Siaya	23	16	13	14	15	81
Total	**123**	**110**	**73**	**72**	**92**	**470**

-Knowledge on the roles, functions and responsibilities of health facility management committees

Respondents were asked whether they know the roles, functions, and responsibilities of HFMC. As shown in Table 11 below, all health facility in charges, SCHMT and CHMT interviewed reported they are aware. Among the community health workers and CHC members the proportion of those who reported they know the roles, functions and responsibilities of the HFMC was 86.4% and 83.3% respectively. The proportion of community members who reported they are aware was the lowest at 67.7% (25) out of 37 interviewed. This finding indicates that there is need to sensitize the community members on the roles and responsibilities of health committees which will also enable them hold the said committees responsible.

Table 12: Distribution of category of respondents' responses on whether they know the roles, functions, and responsibilities of health facility management committee by County

County	Respondents															
	Comm. Member		CHW		CHC		HFMC		In Charge		HCW		SCHMT		CHMT	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Narok	11	8	8	2	9	3	10	2	6	0	4	1	3	0	2	0
Kiambu	4	3	3	1	3	1	3	1	2	0	1	0	3	0	1	0
Isiolo	5	1	4	0	4	0	4	0	2	0	1	0	2	0	2	0
Siaya	5	0	4	0	4	0	4	0	2	0	2	0	2	0	2	0
Total	25	12	19	3	20	4	21	3	12	0	8	1	10	0	7	0

FGDs and KII participants were asked to state what the roles and responsibilities of the health facility management committee is. Analysis of the data indicates that they had a general idea. There was consensus in the FGDs that *they assist the Facility in-charge in the running of the facility, take stock of the facility supplies, disease surveillance and prevalence, manage support staff, represent and protect community interest*. Among the KI the role of facility management committee was described as *overseeing the management of supplies including drugs and maintenance of the facility.* Among the facilities not owned by the government it was found that the facility management committee is tasked with responsibilities of managing the facility. This includes ensuring that needed supplies including drugs, water are available. etc. and oversees the payment of services since the facility being referred to, is not government owned.

-Communication by Health facility management Committee to community members on their roles and responsibilities

Respondents were asked whether the health facility management committee members communicate about their roles with the fellow members in the community. As shown in Table 12 below, most of the respondents who said health facility management committee members communicate about their roles with the fellow members in the community were among the community health committee and health facility management committee at 21 (91.3%) out of 23 and 22 (91.2%) out of 24 interviewed respectively.

The lowest proportion of those who said health facility management committee members communicate about their roles with the fellow members was among the community members at 54.1% (20) out of 37 followed by community health workers at 13 59.1% (13) out of 22 interviewed respectively. The community and the community health workers need to be sensitization on roles and responsibilities of health facility management committee to facilitate them hold health facility committees accountable.

Table 13: Distribution of category of respondents' responses on whether the health facility management committees communicate about their roles with the fellow members in the community by County

County	Respondents																							
	Community Members			CHW			CHC			HFMC			Facility In charges			HCW			SCHMT			CHMT		
	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK
Narok	7	9	2	4	5	1	9	3	0	10	2	0	5	0	1	3	1	0	2	0	1	1	0	0
Kiambu	3	1	3	4	0	0	4	0	0	4	0	0	2	0	0	1	0	0	2	1	0	1	0	0
Isiolo	6	1	0	3	1	0	4	0	0	4	0	0	2	0	0	1	0	0	2	0	0	2	0	0
Siaya	4	1	0	2	2	0	4	0	0	4	0	0	2	0	0	2	0	0	2	0	0	0	0	2
Total	20	12	5	13	8	1	21	3	0	22	2	0	11	0	1	7	1	0	6	1	1	4	0	2

The study collected data from the respondents to determine whether the health facility management committees report back to the community. Table 13 shows that all CHMT members interviewed reported that health facility management committees report back to the community. Proportion of community members who reported health facility management committees report back to the community was the lowest at 50% (18) out of 36 interviewed. This finding calls for capacity building of community members to facilitate them hold health facility management committees accountable. Among the other categories of respondents (CHC, HFMC, facility in charges, health care workers and SCHMT those who reported that the health facility management committees report back to the community were more than 50% of those interviewed.

Table 14: Distribution of respondents' responses on whether the health management committee report back to the community by County

County	Respondents																							
	Community Members			CHW			CHC			HFMC			Facility In charges			HCW			SCHMT			CHMT		
	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK
Narok	6	9	2	4	5	1	5	7	0	7	4	1	5	1	0	2	1	0	2	1	0	2	0	0
Kiambu	3	1	3	4	0	0	4	0	0	2	2	0	2	0	0	1	0	0	2	1	0	1	0	0
Isiolo	6	1	0	3	1	0	4	0	0	4	0	0	2	0	0	1	0	0	2	0	0	2	0	0
Siaya	3	2	0	3	1	0	4	0	0	4	0	0	2	0	0	1	0	0	1	1	0	2	0	0
Total	18	13	5	14	7	1	17	7	0	17	6	1	11	1	0	5	1	0	7	3	0	7	0	0

The respondents who reported that health facility management committee report back to the community were asked to state how the reporting is done. Table 14 below shows chief's Barraza is the one that is mostly used by the health facility management committees to report back to the community at 62 (26.5%) out of 234 who reported a forum used by health facility management committees for reporting back to the community followed by community dialogue at 52 (22.2%) and the religious gathering at 45 (19.2%). The method that is least used by the committee for reporting back to the community is the media followed by workshops/seminars.

Table 15: Distribution of respondents' responses on what forum dispensary/health center/hospital management committee report back to the community by County

County	One on one discussion	Religious Gathering	Community dialogue	Facility Meeting	Chief's Barraza	W/shop/ Seminar	Medi a	Total
Narok	14	21	23	14	26	8	0	106
Kiambu	7	7	4	4	12	1	0	35
Isiolo	12	10	15	5	17	1	0	60
Siaya	6	7	10	1	7	2	0	33
Total	**39**	**45**	**52**	**24**	**62**	**12**	**0**	**234**

Other fora that are used by the health facility management committee to report back to the community include women groups, school health Programme, school meetings, CHWs and during vaccine campaigns.

It emerged from FGD health facility committee members do not always report back to the community. Some of the sentiments made include *"No reporting back. We see them working but they don't report back to the community" On their part* religious leaders KI indicate that a few of them report back while others do not. One of those who said they report back to the community also indicated how it is done "Yes *they report back and it is through chief Barraza's and also door to door visits."* Another religious leader KI had this to say *"They give information in churches, chief Barraza, CHWs and CBOs forums"*

3.2.3. Transparency and Accountability at Dispensary/Health Centre Level

-Involvement of public in discussing performance and progress of the health facility nearest to them

The survey collected data to determine from the respondents whether in the past three years, their nearest health facility held any meeting that involved the public to discuss the performance and progress of the facility. Table 15 below indicate that among all category of respondents except community members, 50% and above of those interviewed reported that in the past three years, their nearest health facility held a meeting that involved the public to discuss the performance and progress of the facility.

Among the community members, 26 (36.6%) out of 71 interviewed reported that that in the past three years, their nearest health facility held a meeting that involved the public to discuss the performance and progress of the facility while a total of 45 (63.5%) reported that their dispensary/health center/hospital had not held any meeting that involved the public to discuss the performance and progress of the facility or did not know.

Table 16: Distribution of respondents' responses on whether in the past three years, their nearest health facility held any meeting that involved the public to discuss the performance and progress of the facility by County

County	Respondents																							
	Community Members			CHW			CHC			HFMC			Facility In charges			HCW			SCHMT			CHMT		
	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK
Narok	9	23	4	4	7	1	5	7	0	7	4	1	4	2	0	3	1	1	0	2	1	1	1	0
Kiambu	3	3	5	3	1	0	1	3	0	2	2	0	1	1	0	0	1	0	2	1	0	1	0	0
Isiolo	7	5	0	3	1	0	3	1	0	2	2	0	1	1	0	1	0	0	2	0	0	1	1	0
Siaya	7	3	2	3	1	0	4	0	0	2	1	1	0	2	0	2	0	0	1	1	0	1	1	0
Total	26	34	11	13	10	1	13	11	0	13	9	2	6	6	0	6	2	1	5	4	1	4	3	0

Community members and community health workers (CHWs) were asked whether they are aware of any fora available at community level that seek their opinions and ideas about how facility should be run. Analysis of data collected as depicted in Table 16 below shows that among the community members, 35 (49.3%) and 46 (64.8%) out of the 71 interviewed were aware and not aware respectively. Among CHWs, 14 (60.9%) and 9 (39.1%) out 23 interviewed were aware and not aware respectively. These findings indicate that there is need to create awareness among community members on the fora that are available at community level where they can give their opinions and ideas about running of the health facility.

Although there were more CHWs who were aware of fora at community level where they can give their opinion and ideas there is still need to create awareness among them. This is to improve on the pool of CHWs who are aware and should be encouraged to share the information with the community members as they visit the households for primitive and preventive health services.

Table 17: Distribution of community members and community health workers responses on awareness of community level fora that seek their opinions and ideas about how facility should be run by County

County	Respondents				Total
	Community Member		CHWs		
	Yes	No	Yes	No	
Narok	24	21	6	5	
Kiambu	6	6	3	1	
Isiolo	3	9	2	2	
Siaya	2	10	3	1	
Total	35	46	14	9	

It emerged from FGDs that community members are not involved in the running of their nearest health facilities including discussing progress and performance of these facilities. This is what was said by some of the participants "*We should be involved but they are not involving us in running the facility or discussing performance and progress. We see the progress when we come to facility for health care services e.g. New tank, New staff etc." On their part* religious leaders KI noted that community members should be involved in running of the facilities. Some called for frequent meetings with the management committee.

- Customer Service Charter

Respondents were asked whether they have ever heard or seen a dispensary/health center/hospital customer service charter. The responses as depicted in Table 17 below show that all facility in charges,

health care workers, SCHMT and CHMT interviewed said they have heard or seen the costumer charter. CHC and HFMC members who reported they have seen a customer service charter in their nearest facility are 19 (79.2%) and 22 (91.2%) out of 24 interviewed per category of respondents. Community members and the CHWs who reported they have seen or heard a customer service charter are 31 (72.1%) and 14 (66.7%) out of 43 and 21 interviewed respectively. As per the finding, there is a need to scale up awareness creation on the service charter and what it entails particularly among the community health workers who are the link between health facilities and the communities.

Table 18: Distribution of respondents' responses on whether they have ever heard or seen a customer service charter and whether it is displayed at the facility by County

County	Respondents															
	Comm. Member		CHW		CHC		HFMC		In Charge		HCW		SCHMT		CHMT	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Narok	15	5	8	2	10	2	10	2	6	0	5	0	3	0	2	0
Kiambu	6	1	3	1	3	1	4	0	2	0	1	0	3	0	1	0
Isiolo	2	6	1	3	3	1	4	0	2	0	1	0	2	0	2	0
Siaya	8	0	3	1	3	1	4	0	2	0	2	0	2	0	2	0
Total	31	12	14	7	19	5	22	2	12	0	9	0	10	0	7	0

The respondents who said they have ever heard or seen the customer service charter were asked whether their health facility has a service charter displayed. Analysis of data collected showed that all CHMT members interviewed reported that the service charter is displayed at the health facilities nearest to them. Although over 65% of the other categories of respondents interviewed also reported that the service charter is displayed at the health facility nearest to them, there is a need to sensitize all categories of respondents on the importance of a customer charter to enable them hold the facility management accountable in the event it is not followed.

The respondents who reported that the customer service charter is displayed at the facility nearest to them were then asked if in their opinion/experiences the service charter is followed. As shown in the Table 18 below, all health care workers CHMT members interviewed reported that the customer service charter is followed. The number of community members who reported that the service charter is followed is the lowest at 17 (47.2%) out of 36 interviewed. There is therefore need to build capacity of community members to enable them hold the facility management accountable on why the service charter is not followed.

Table 19: Distribution of respondents' responses on whether the customer service charter is followed by County

County	Respondents																							
	Community Members			CHW			CHC			HFMC			Facility In charges			HCW			SCHMT			CHMT		
	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK
Narok	5	11	1	3	3	1	6	5	0	8	1	0	4	0	0	3	1	0	3	0	0	2	0	0
Kiambu	5	1	0	3	0	0	1	0	0	2	1	0	1	0	0	0	1	0	1	1	0	1	0	0
Isiolo	2	0	3	3	0	0	2	0	0	2	0	0	1	0	0	0	0	0	1	1	0	2	0	0
Siaya	5	3	0	3	1	0	1	1	1	3	1	0	2	0	0	2	0	0	2	0	0	2	0	0
Total	17	15	4	12	4	1	10	6	1	15	3	0	8	0	0	5	2	0	7	2	0	7	0	0

FGDs participants and religious leaders who said they know what a customer service charter is and also reported that it is displayed in their nearest health facilities said that it is partially followed

-Complaints collection mechanisms

The survey collected data to determine whether health facility nearest to respondents collect complaints from clients. Table 19 below shows that all CHMT members interviewed reported that facilities collected complaints from clients followed by SCHMT at 7 (70%) out of 10 interviewed. Most of the community members and community health workers interviewed, reported that the facilities do not collect complaints from clients at 67(93.1%) and 21(87.5%)) out of 72 and 24 interviewed respectively.

Among the CHC and HFMC 14 (70%) and 14 (60.9%) out of 20 and 23 interviewed reported health facilities do not collect complaints respectively. Majority of facility in charges and healthcare workers also reported that facilities do not collect complaints from clients at 6 (54.5%) and 6 (75%) out of 11. These findings indicate that there is a need to sensitize the facility's management on the importance of collecting complaints from clients which if analyzed and effectively addressed can be used to improve service provision and relationship between the facility managers and the community. In addition, the capacity of the community needs to be built to enable them demand for a mechanism to be put in place through which complaints can be aired.

Table 20: Distribution of respondents' responses on whether their nearest health facility collects complaints from clients by County

County	Respondents															
	Comm. Member		CHW		CHC		HFMC		In Charge		HCW		SCHMT		CHMT	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Narok	4	32	1	11	4	6	4	7	3	2	0	4	2	1	2	0
Kiambu	0	12	2	2	2	2	2	2	1	1	1	0	2	1	1	0
Isiolo	0	12	0	4	0	2	1	3	0	2	0	1	1	1	2	0
Siaya	1	11	0	4	0	4	2	2	1	1	1	1	2	0	2	0
Total	5	67	3	21	6	14	9	14	5	6	2	6	7	3	7	0

Respondents who reported that facilities collected complaints from clients were then asked to state the mechanisms used for collecting the said complaints. Table 20 below shows that out of the 96 responses gathered on a mechanism to collect complaints, the most frequently mentioned mode of collecting complaints is the suggestion box at 45 (46.9%) followed by the chief's Barraza at 30 (31,3%). The findings indicate that there is a need to sensitize the health managers on the need to put in place mechanisms for collecting complaints from the clients. In addition, there is need to create awareness among community members on the existence of mechanisms put in place for collecting complaints and why it is important to give feedback to health managers.

Table 21: Distribution of respondents' responses on mechanisms used for collecting complaints by County

County	Suggestion Box	Customer Desk	Chiefs Baraza	Total
Narok	20	6	13	39
Kiambu	11	7	4	22

Isiolo	5	3	8	16
Siaya	9	5	5	19
Total	45	21	30	96

Other means of collecting complaints include during outreaches, monthly meetings with CHWs, community dialogue, through politicians or face to face with health care workers.

FGDs and religious leaders KI explored whether their nearest health facilities collect complaints from clients. There was consensus among the respondents that *health facilities collect complaints through: - Suggestion box, one on one discussion and at times they collect through questionnaires. It also emerged that* complaints are also collected by the facility in charge, through CHWs, customer desk, through the chief and through the facility management committee members. On whether the facility give feedback on the complaints, it emerged that they do not. *"No feedback meetings are held to address complaints e.g. if drugs are out of stock, no one informs us of the availability once they are stocked".*

-Complaints Raised by Clients and Readdress

Respondents were asked whether they have ever heard anybody complain to the facility. All those interviewed said they know of at least one client with a complaint as shown in Table 21 below. Health facility in charges reported having heard most complaints at 11 (91.7%) out 12 interviewed followed by the healthcare workers at 8 (88.9%) out of 9. These findings indicate that there is need to put a mechanism in place to collect complaints to ensure healthcare providers time is utilized in provision of health care services and not listening to clients' complaints.

Table 22: Distribution of respondents' responses on whether they have ever heard anybody complain to the facility by County

County	**Respondents**																							
	Community Members			**CHW**			**CHC**			**HFMC**			**Facility In charges**			**HCW**			**SCHMT**			**CHMT**		
	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK
Narok	5	11	1	3	3	1	6	5	0	8	1	0	4	0	0	3	1	0	3	0	0	2	0	0
Kiambu	5	1	0	3	0	0	1	0	0	2	1	0	1	0	0	0	1	0	1	1	0	1	0	0
Isiolo	2	0	3	3	0	0	2	0	0	2	0	0	1	0	0	0	0	0	1	1	0	2	0	0
Siaya	5	3	0	3	1	0	1	1	1	3	1	0	2	0	0	2	0	0	2	0	0	2	0	0
Total	17	15	4	12	4	1	10	6	1	15	3	0	8	0	0	5	2	0	7	2	0	7	0	0

The respondents who said they have heard a client complain were asked to state the complaint they heard being lodged. Table 22 below shows that the complaints mostly lodged by clients are medical and drug supplies; human resources and service delivery in that order.

Table 23: Distribution of respondents' responses on complaint they heard being lodged by County

Response	Counties				Total
	Narok	Kiambu	Isiolo	Siaya	
Medical and drug supply systems	31	3	9	16	59
Human resources	20	6	10	9	45
Service delivery	13	6	2	1	22
Health information	1	0	0	1	2
Financing of health systems	1	0	0	2	3

Leadership and governance	1	0	0	3	4
Total	67	15	21	32	135

Respondents were then asked to state how the complaints were addressed. Analysis of the data showed that most complains are addressed through talking to clients and asking them to be patient as they resolve the issues. Holding of facility management meetings to try and resolve the issue is also frequently mentioned by respondents followed by community dialogue, talking positively to the staff and the facility in charge to improve and; reporting the matter to high level and holding Barraza's.

These findings indicate that there is need to support the health managers to streamline how they will be addressing complaints raised by clients. In addition, once the process of addressing the complaints is streamlined, community awareness creation should follow for better coordination of lodging complaints.

3.3. Community involvement in Planning and Budgeting

3.3.1 Health Facility Level

Data was collected to determine whether health facility nearest to the respondents involve the community in planning and budgeting for the facility every financial year. Table 23 below indicate that majority of HFMC (58.3%), facility in charges (75%), healthcare workers, SCHMT (60%) and CHMT (85.7%) interviewed per category reported that health facilities involve the community in planning and budgeting for the facility every financial year.

Among the community members, 57 (80.3%) out of 71 interviewed reported that the community is not involved in planning and budgeting for the facility every financial year. This was followed by CHC members at 14 (63.6%). There was an equal number of CHWs who reported that the facility involves the community in planning and budgeting every financial year or do not at 11 (45.8%) out of the 22 interviewed per category.

Table 24: Distribution of respondents' responses on whether their nearest health facility involve the community in planning and budgeting for the facility every financial year by County

County	**Respondents**																							
	Community Members			**CHW**			**CHC**			**HFMC**			**Facility In charges**			**HCW**			**SCHMT**			**CHMT**		
	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK
Narok	2	29	4	4	6	2	3	9	0	7	5	0	5	1	0	3	2	0	2	1	0	2	0	0
Kiambu	2	9	1	3	1	0	2	2	0	2	2	0	2	0	0	0	0	0	2	1	0	1	0	0
Isiolo	2	9	1	3	1	0	2	2	0	2	2	0	1	1	0	1	0	0	1	1	0	1	1	0
Siaya	1	10	1	1	3	0	0	3	1	3	1	0	1	1	0	1	1	0	1	1	0	2	0	0
Total	7	57	7	11	11	2	7	14	1	14	10	0	9	3	0	5	3	0	6	4	0	6	1	0

Respondents were also asked whether they are aware that community members should be involved in planning and budgeting for their health facility nearest to them**.** Analysis of data gathered showed that 100% of HFMC, facility in charges, SCHMT and CHMT interviewed reported they are aware that community members should be involved in planning and budgeting for their respective health facility. Majority of community members (66.7%), CHWs (91.3%) and CHC (70.8%) interviewed also reported that community members should be involved in planning and budgeting for their respective health facility.

As per these findings, over 65% of community members are aware they should be involved in planning and budgeting for their respective health facilities yet about 80% reported that they are not involved as

stated above. There is therefore a need to sensitize the communities that it is their right to be involved in planning and budgeting for the facility every financial year.

Analysis of information gathered through FGDs and KIIs revealed that community members desire to be involved in planning and budgeting for their nearest health facilities, though this is not the practice. It also emerged some of the participants are not sure whether they should be involved. It further emerged that facility management committee does not give reasons for not involving community members in the planning and budgeting. One of the statements made during the FGDs was *"We are not involved in Budgeting and Planning and when we ask questions no answer is given"* This is an advocacy issue to both the facility management committees and the county health departments to involve the communities in planning and budgeting.

-Facility Annual Operation Plan (AOP)

On whether facilities have Annual Operational Plan (AOP), 100% of facility in charge and CHMT interviewed reported that their health facilities have an AOP followed by SCHMT at 90% and HCW at 77.7%. CHC members interviewed were the least informed at 54.2% followed by HFMC at 66.7%. These findings indicate that once the AOP is finalized there is need to disseminate it to key stakeholders.

The respondents who reported that their health facility has the AOP were asked to state, who is involved in developing facility AOP and budgeting in their facility. Analysis of data collected showed that the health facility management committee was the most frequently mentioned as the one involved in developing facility AOP and budgeting. The facility in charge, service providers, CHMT and the CHEWs followed in that order. To foster ownership of the AOP, the facility management should involve key stakeholders in its development.

Data was also collected to determine whether the facility budget has the same priorities as the facility's annual work plan. As shown in Table 24, 83.3% and 77.8% of facility in charges and healthcare workers interviewed reported that the facility budget has the same priorities as the facility's annual work plan respectively. CHMT interviewed who reported that the facility budget has the same priorities as the facility's annual work plan were 4 (57.1%) while 77.7% of SCHMT reported that the priorities are not the same. Among the CHC and HFMC interviewed, 10 (41.7%) and 15 (62.5%) reported that the facility budget has the same priorities as the facility's annual work plan respectively. Budget should be based on the priorities stipulated in the AOP. Therefore, there is a need to capacity build managers in the health facilities on planning and budgeting to ensure that the AOP and the budget are in sync.

Table 25: Distribution of respondents' responses on whether the facility budget has the same priorities as the facility's annual work plan by County

County	Respondents																	
	CHC			HFMC			Facility In charges			HCW			SCHMT			CHMT		
	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK
Narok	5	4	3	9	1	2	6	0	0	4	1	0	1	2	0	1	1	0
Kiambu	2	1	1	2	1	1	1	1	0	1	0	0	1	1	0	1	0	0
Isiolo	3	1	0	2	1	1	2	0	0	1	0	0	0	2	0	2	0	0
Siaya	0	2	2	2	2	0	1	1	0	1	1	0	0	2	0	0	2	0
Total	10	8	6	15	5	4	10	2	0	7	2	0	2	7	0	4	3	0

3.3.2. County Planning and Budgeting

-Awareness of county development plans

Respondents were asked whether they have ever heard or seen their county development plans. Analysis of the data as depicted in Table 25 below showed that 90% and 85.7% of 10 SCHMT and 7 CHMT interviewed said they have ever heard or seen their county development plan. Among the health care workers, 50% of 8 interviewed reported they have ever heard or seen their county development plan. Majority of community members (75.4%), CHC (70.8%), HFMC (58.3%) and facility in charges (66.7%) reported they have never heard or seen their county development plan. These findings indicate that to foster ownership, there is a need to involve all key stakeholders when developing the county plan and once finalized, it should be disseminated wildly.

Table 26: Distribution respondents' responses on whether they have ever heard or seen their county development plan by County

County	Respondents															
	Comm. Member		CHW		CHC		HFMC		In Charge		HCW		SCHMT		CHMT	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Narok	8	25	3	9	3	9	4	8	2	4	2	2	2	1	2	0
Kiambu	1	11	1	3	0	4	2	2	1	1	0	1	3	0	0	1
Isiolo	2	10	4	0	2	2	2	2	0	2	1	0	2	0	2	0
Siaya	6	6	3	1	2	2	2	2	1	1	1	1	2	0	2	0
Total	17	52	11	13	7	17	10	14	4	8	4	4	9	1	6	1

On whether county budget has the same priorities as the county's development plan, analysis of collected data showed that majority of HFMC (52.9%), health care workers (57.1%) and the CHMT (57.1%) interviewed said county budget has the same priorities as the county's development plan. Majority of facility in charges (55.6%), community health workers (88.7%) and SCHMT (60%) interviewed reported that the county budget does not have the same priorities as the county's development plan or did not know. If the counties are to effectively implement their county development plans, they need to align the county budget and the development plans. If the priorities as stipulated in the current development plans have been addressed, there is need to revise it and ensure involvement of key stakeholders including the community for identification of needs on the ground.

Analysis of data collected to determine whether there are reasons given for choices made by leaders while preparing the county budget in each financial year revealed as shown in Table 26 below, that 100% of the CHMT members interviewed said there are reasons given for choices made by leaders who prepare the county budget in each financial year. Community members (88.9%), CHWs (75%), CHC (79.2%) HFMC (66.7%), facility in charges (77.8%), HCW (55.6%) and SCHMT (55.6%) out of those interviewed reported they do not know or there are no reasons given for choices made by leaders while preparing the county budget in each financial year.

From these findings majority of the respondents either reported there are no reasons given for choices made by leaders while preparing the county budget in each financial year or did not know. There is therefore need to build the capacity of stakeholders to enable them hold leaders accountable for any choices they make as they prepare the county budget. The citizenry also needs to be sensitized on their right to be involved in county budget making process.

Table 27: Distribution of respondents' responses on whether there are reasons given for choices made by leaders while preparing the county budget in each financial year by County

County	Respondents							
	Community Members	CHW	CHC	HFMC	Facility In charges	HCW	SCHMT	CHMT

	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK
Narok	2	19	15	2	4	6	3	6	3	4	6	2	3	0	3	1	3	1	1	0	1	2	0	0
Kiambu	2	5	5	1	1	2	0	0	3	1	1	2	0	0	1	0	1	0	2	1	0	1	0	0
Isiolo	0	7	5	0	4	0	1	1	2	1	2	1	0	1	1	1	0	0	1	1	0	2	0	0
Siaya	4	4	4	3	1	0	0	1	3	2	1	1	1	1	0	2	0	0	0	2	0	2	0	0
Total	8	35	29	6	10	8	4	8	11	8	10	6	4	2	5	4	4	1	4	4	1	7	0	0

-Factors influencing budget cuts, planning role played by county officials and community involvement as perceived by county officials

To determine factors that inform budget cuts, data was collected from county officials and county assembly members through KII. Analysis of information gathered reveals that the factors that influence budget cuts are: availability of funds, disbursement delays by the central government, county priorities and county competing priorities.

The county officials and members of the county assembly (MCAs) KI respondents were asked what their role is in planning. Some MCAs said they have no role in planning and budgeting while others reported their roles as follows: advising the community planning, to ensure budgets are done according to the law, budgets are properly implemented, authorize withdrawal of revenues, monitoring budget implementation, to ensure good budget preparation at county level for continuous provision of health.

The county planning and development officers reported their roles in planning and budgeting as coordination of various departments and sectors, development of County integrated plan and linking planning to budget. The county directors of health reported their role as Lobbying for finances for the planning process, liaison between the CHMT and the Chief Officers, coordination of stakeholders during planning, policy communication in planning and coordinating the planning cycle in the health sector.

County officials and MCAs respondents of KII were also asked to state how the community is involved in planning and budgeting. They all said the community is involved in planning and budgeting through the fora that are held at sub-county level at the start of the process to collect community members views and before the budget is passed at the county assembly to ensure communities views are incorporated in the final county budget.

-Budget Allocation to Health Sector

The survey collected data to establish whether according to the respondents their county government allocates enough money for the health sector. As shown in Table 27 below, all facility in charges, CHC, HCW, SCHMT and CHMT said their county government does not allocates enough money for the health sector. Majority of community members (88.7%), (CHWs (91.7%), and HFMC (91.7%) of those interviewed said their county government does not allocate enough money for the health sector or did not know respectively.

As per the findings, there is need to build the capacity of the citizens to enable them demand adequate allocation of money to the health sector from the county government to the maximum of its available resources for the realization of their health rights.

Table 28: Distribution of respondents' responses on whether their county government allocates enough money for the health sector by County

County	**Respondents**																							
	Community Members			**CHW**			**CHC**			**HFMC**			**Facility In charges**			**HCW**			**SCHMT**			**CHMT**		
	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK	Y	N	DK
Narok	3	12	20	2	2	8	0	7	5	1	8	3	0	6	0	0	5	0	0	3	0	0	2	0

Kiambu	2	2	8	0	2	2	0	4	0	0	4	0	0	2	0	0	2	0	0	3		0	1	0
Isiolo	0	2	10	0	4	0	0	3	1	0	3	1	0	2	0	0	2	0	0	2	0	0	2	0
Siaya	3	7	2	0	4	0	0	2	2	1	3	0	0	2	0	0	2	0	0	2	0	0	2	0
Total	8	23	40	2	12	10	0	16	8	2	18	4	0	12	0	0	11	0	0	10	0	0	7	0

FGDs and religious KI were asked whether their county government allocates enough money to the health sector. All of them said their county government does not allocate enough money to health sector. A participant had this to say*" County government does not allocate adequate funds because there are drugs stock outs, facility lack a fence and grounds are poorly maintained."* Another one said "*Funds allocated are not enough because casuals are not paid; there are inadequate equipment for delivery, Insufficient/inadequate drugs, unsettled electricity bills and therefore services not offered at night."*

The respondents were asked to state at least three health priority areas that they think their county government should allocate more money to. Analysis of information gathered revealed that in Narok, Kiambu and Siaya counties, drugs and supplies and; human resources for health including capacity building had the most responses as priority areas that should be allocated more money by their county government. In Narok and Kiambu counties build/upgrade maternity wings was the third priority area.

In Siaya, county the third priority area was a tie between human resource including capacity building, reproductive health and maternal, newborn and child health (RMNCH) and water and sanitation. In Isiolo County, the three priority areas are Reproductive health and maternal, newborn and child health (RMNCH), drugs and supplies and expand/upgrade existing health facilities e.g. build wards.
These findings indicate that county residents know what their priority areas of intervention are and therefore county officials need to engage with them when preparing the county budget.

Data was collected from FGDs and KII participants on the three health priority areas that the county government should allocate more resources to. As per their responses, the priority areas are MNCH, drugs and human resources in that order.

-Awareness of respondents on how they can influence budget making process

Respondents were asked whether they are aware they can influence/engage with the county government to allocate more money to their community health priority areas. As shown in Table 28 below, majority of respondents in all categories except CHMT reported that they are not aware they can influence/engage with the county government to allocate more money to their community health priority areas.

The CHMT members who reported they are aware they can influence/engage with the county government to allocate more money to their community health priority areas are 5 (71.4%) out of 7 interviewed. Among the CHC none of the respondents was aware they can influence/engage with the county government to allocate more money to their community health priority areas. These findings indicate that there is need to create awareness among the stakeholders that they can influence/engage with the county government to allocate more money to their community health priority areas.

Table 29: Distribution of respondents' responses on whether they are aware they can influence/engage with the county government to allocate more money to their community health priority areas by County

County	**Respondents**															
	Community Member		**CHW**		**CHC**		**HFMC**		**Facility in charge**		**HCW**		**SCHMT**		**CHMT**	
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Narok	2	33	3	9	0	12	1	11	2	4	1	4	1	2	1	1
Kiambu	0	12	0	4	0	4	0	4	0	2	0	1	0	3	1	0

Isiolo	2	10	2	2	0	4	0	4	0	2	0	1	0	2	2	0
Siaya	0	12	0	4	0	4	1	3	1	1	2	0	0	2	1	1
Total	4	67	5	19	0	24	2	22	3	9	3	6	1	9	5	2

Analysis of information collected from religious KI indicate that they are also not aware they can influence/engage county officials when preparing the county budget to allocate more money to the health sector.

Respondents were then asked whether they have ever tried to influence/engage with county government officers while they are making the county government budget. Analysis of data collected revealed that majority of respondents in all the categories except the CHMT said they have never tried to influence/engage with county government officers while they are making the county government budget. These calls for capacity building of the stakeholders in the counties to enable them have meaningful engagement with county officials while they are making the county government budget.

Those who said they have tried to influence/engage with the county government officials while making the county government budget were asked to state how they did it. Most responses as reported was trying to influence the budget through the MCA followed by proposal development. There is therefore need to sensitize the stakeholders on the different fora for influencing/engaging with the county government officials while making the county government budget as provided for in Kenyan laws.

-Capacity of county and health budget committees as perceived by the county officials

County officials and MCAs KII respondents were asked to state what they thought on the capacity of county budget and health budget committees on budget making. Most of the KII respondents could not with certainty state whether the county budget and health budget committees have the capacity or not on budget making. The responses given were: *I think they have the capacity or I don't think they have the capacity.* On who provides technical assistance, respondents stated that it is the national treasury, the office of the controller and in same by county legal officers for legal aspects

3.4. Other Findings

-Gender perspective

Some data collected using the questionnaire was further analyzed to determine gender equality in the four counties. Data selection was based on the understanding that further analysis on it would give an indicative pointer of the gender perspective. As shown in Table 29 below, more men than women had secondary and above level of education, were aware of health rights and governance issues. These findings indicate that there is need to support gender responsiveness initiatives in the four counties.

Table 30: Distribution of responses on some selected variable disaggregated by Gender

Variables	Responses	Men	Women	Total	Percentage	
					Men	women
Level of Education	Primary and below	4	13	17	23.5	76.5
	Secondary and above	42	24	66	63.6	36.4
Aware of health rights of consumers of health services	Yes	44	36	80	55	45
	No	2	1	3	66.7	33.3
Aware of healthcare workers health rights	Yes	39	35	74	52.7	47.3
	No	7	2	9	77.8	22.2
Aware Kenya's constitution guarantees health rights including RH	Yes	42	33	75	56	44
	No	4	4	8	50	50

Health committee selected by community	Yes	43	1	44	97.7	2.3
	No	36	1	37	97.3	2.7
Aware of policies/rules for selecting health committee members	Yes	39	5	44	88.6	11.4
	No	27	10	37	73	27
Aware of roles and functions of health committees	Yes	40	34	74	50.1	45.9
	No	6	3	9	66.7	33.3
Letter of appointment as a health committee member	Yes	14	11	25	56	44
	No	31	25	56	55.4	44.6
Trained as a committee member	Yes	25	19	44	56.8	43.2
	No	20	16	36	55.6	44.4
Aware community should be involved in planning	Yes	35	11	46	76.1	23.9
	No	32	4	36	88.9	11.1
Heard or seen county development plan	Yes	29	18	47	61.7	38.3
	No	16	18	32	47.1	52.9

4.0. Conclusion and Recommendations

4.1. Conclusion

The linkage between health, human rights and community participation in health governance cannot be over emphasized in ensuring the realization of the right to health by all Kenyans. However, from the study it was unfortunate that this linkage did not emerge from the interviews and discussions in FGD and with KII as strongly as it should. As a result, access to quality health services remains a “wish” rather than a fundamental human right which citizens must demand from the state. This is the case despite Kenya adopting human rights-based approach to healthcare service delivery based on the Universal Declaration of Human Rights that the county is a signatory. The Constitution of Kenya (2010), domesticated this through Article 43 (1) (a) which states 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. The Human Rights-Based Approach (HRBA) is therefore the guiding principle of Kenya’s health care system that all partners and stakeholders should be empowered to embrace.

It is hoped that with improved awareness on human rights, constitution and health sector policy framework citizens will be in a more informed position to demand quality health services from both national and county government. Similarly, they will be in a better position to select able representatives in Health Facility Committees, County Health Management Boards (CHMB) and hold them accountable in the execution of the duties and responsibilities as contained in their terms of reference.

It emerged from the survey that the national values and principles of governance as contained in Article 10 (2) (b) of the Constitution - human dignity, equity, social justice, inclusiveness, equality, human rights, non-discrimination and protection of the marginalised is not fully adhered to. Though the county governments in the four counties have attempted to adhere to this article, the practicality of it should move a notch higher. Currently most respondents recognised women as a special group more than all the others as stipulated in the Constitution. The need for the county authorities to ensure that there is inclusiveness in policy, planning and budgeting, and accessibility of all services by all citizens, including the youth, women and the disabled should remain an aspiration for all stakeholders.

It has emerged that most citizens are ignorant and lack enough information about the human rights-based approach to public services. Furthermore, it emerged that community members and service providers do not know, or they have insufficient capacities to engage with county government officials in decision making process such as planning and budget making process. It is therefore paramount that both duty bearers and rights holders are enabled to acquire skills and capacities for interacting with one another and for reaching out to decision makers in higher offices. This is especially so during the policy, planning and budget making process

4.2. Recommendations

1. There is need to comprehensively capacity build all categories of respondents on health rights. They being the duty bearers and rights holders, understanding and being able to articulate the health rights will facilitate them carry out their mandate of protecting and promoting the right to health and ensuring accountability respectively.
2. From the study findings on the health committees, there is an indication of varying levels of knowledge on the establishment and functions of the health committees including their responsibilities towards the community. However, the demand and supply for rights and obligations must go hand in hand. Both right holders and duty bearers must have their capacity to seek and respond at par. In this case the project, the county governments and other stakeholders should enable the two to meet basic requirements in order for public officials and institutions to be receptive to citizens' voice – not only in terms of their willingness or capacity to hear but also, crucially, to act – and to behave in ways consistent with the spirit of accountability.
3. The new Constitution and devolution of health sector was intended to ensure that the country has an effective grassroots governance, management and service delivery. This has brought health sector decision-making and action as close as possible to the community and individual households. However, there is need to strengthen all community decision making committees such as Community Health Committee (CHC), Facility Health Committees (FHC), Sub-County Health Committees, County Health Committees and respective health stakeholders forums in each of these levels in order to effectively identify community health needs and participate more actively in the improvement of community health care services. This should include providing channels through which citizens can express their voice and hold county government including elected members of community decisions units to account
4. According to the study findings, there is inadequate involvement of the community in the running of the health facilities nearest to them. This calls for sensitization of the community on what their role should be and how they can be involved in the running of the health facility nearest to them.
5. A significant proportion of respondents reported that they have seen or heard about a customer service charter, it is displayed at the health facility nearest to them and it is followed. However, it is important to sensitize the all categories of respondents on the importance of the service charter to enable them hold the facility management accountable in the event it is not followed.
6. Most respondents except the CHMT and SCHMT reported that facilities do not collect complaints from clients and when collected they are hardly addressed. Therefore, there is a need to build the capacity of the stakeholders to enable them hold the facility management accountable. Health care workers also need to be sensitized on the importance of collecting complaints from the clients which if analyzed and effectively addressed can be used to improve service provision and relationship between the facility managers and the community
7. The study finding indicates that community members are hardly involved in planning and budgeting by their nearest health facility but said they should. Communities therefore need to be capacity build to enable them participate in planning and budgeting for their facilities in addition to holding their e facilities' mangers accountable. It is also imperative to sensitize health care workers on the need to involve the community in planning and budgeting to foster ownership.
8. Majority of community members (75.4%), CHC (70.8%), HFMC (58.3%) and facility in charges reported they have never heard or seen their county development plan. These findings indicate that in order to foster ownership, there is a need to involve all key stakeholders when developing the county plan and once finalized, it should be disseminated wildly.
9. Majority of facility in charges (55.6%), community health workers (88.7%) and SCHMT (60%) interviewed reported that the county budget does not have the same priorities as the county's development plan or did not know. County officials need to be sensitized on the need to align their annual budgets with the priorities as stipulated in the development plan
10. Study findings indicate that reasons are hardly given for choices made by the county officials when preparing the county budget. There is therefore need to build the capacity of stakeholders to enable them hold leaders accountable for any choices they make as they prepare the county budget. The citizenry also needs to be sensitized on their right to be involved in county budget making process

11. Majority of respondents in all categories except CHMT reported that they are not aware they can influence/engage with the county government to allocate more money to their community health priority areas. These findings indicate that there is need to create awareness among the stakeholders that they can influence/engage with the county government to allocate more money to their community health priority areas.
12. County officials and MCAs articulation of their roles in planning and budgeting as reported shows there is a gap in the way they understand them. This calls for capacity building of county officials and MCAs on their roles in planning and budgeting
13. Under gender perspective the findings show that more men than women were doing better in all variables selected for further analysis. These findings indicate that there is need to support gender responsiveness initiatives in the four counties

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