REPORT ON THE COMMUNITY DIALOGUE FORUM ON THE RIGHT TO HEALTH

FAMILY LIFE TRAINING CENTRE

23RD APRIL 2009

TABLE OF CONTENTS

LIST OF ABBREVIATIONS 2
1.0 BACKGROUND 3
2.0 Climate Setting 5
2.1 Introductions 6
3.0 OUTPUTS OF THE FORUM 6
3.1 Strengthening Community Participation in the Health sector 7
3.2 HEALTH SITUATION IN MBEERE DISTRICT 9
3.2.1 Plenary Discussion 10
3.3 Human Rights principles (Right Based Approach) 11
3.3.1 Right to Health in the context of Kenya 14
3.3.2 Right-Based Approach to Health 15
3.3.2.1. Rights Holders and Duty Bearers 15
3.3.2.2. RBA Principles 16
3.3.2.3. Value added with RBA 16
3.3.3 Plenary Discussions 18
4.0 Way Forward 20
5.0 Conclusion 21
6.0 Evaluation 22
ANNEX 1: HEALTH INDICATORS IN MBEERE DISTRICT 24
ANNEX 11: LIST OF PARTICIPANTS 26

LIST OF ABBREVIATIONS

CBO	Community Bases Organization
CEDAW	Convention on Elimination of All Forms of Discrimination Against women
CHW	Community Heath Worker
CRC	Convention on the Rights of the Child
DHMB	District Health Management Board
DHMT	District Health Management Teams
DMOH	District Medical Officer of Health
FBO	Faith Based Organization
HMB	Health Board Management
ICCPR	International Covenant on Civil and Political Rights
ICERD	International Convention on the Elimination of All Forms of Racial Discrimination
ICESCR	International Covenant on Economic, Social and Cultural Rights
KHRC	Kenya Human Rights Commission
MDGs	Millennium Development Goals
MOH	Ministry of Health
RBA	Right Based Approach
UNGASS	United nations General Assembly Special Session

1.0 BACKGROUND

Lack of consciousness of health as a right remains a fundamental challenge among Kenya citizens irrespective of their socio-economic status. The widespread ignorance of economic, social and cultural rights, inadequate participation of grass root organizations, lack of transparency and accountability has contributed to poor governance in the health sector. This has drastically affected the quality of life for the most vulnerable Kenyans including women and children. A health democracy in Kenya relies on the ability of communities to hold their leaders accountable for their human rights obligations, their policy decisions and their resource allocations.

As Kenya strives to build its democratic structures, citizens at grassroots should hold their leaders accountable for their human rights obligations, their policy decisions and their resource allocations. However, to achieve this health manager must fully understand their mandates, roles and responsibilities in promotion of the right to health. The civil society and grass root communities must understand the concept of human rights and enhance their capacity, in order to engage effectively in policy and decision making processes, monitor government's performance and demand for the quality services the utilize a right based approach.

To overcome this challenge, Health Rights Advocacy Forum (HERAF) hopes to increase then citizen's awareness on the right to health. The organization brings together health professionals, NGOs, People Living with HIV/AIDS and other human rights organizations working and interested in the right to health to advocate for health as a fundamental human right.

The purpose of this dialogue forum was to bring together representatives from grass root civil society organizations, health care providers, health facility managers, health facility committee members and government health officials to assess their understanding on the right to health and discuss the right to health.

Specifically the purpose of the dialogue was to bring together Mbeere District health stakeholders to discuss and educate stakeholders on the right to health, raise awareness on the current health policies both national and international and their implications on maternal and child health care indicators.

The Expected outputs of the forum included;

- Increased awareness on the right to health among Mbeere district Health stakeholders
- Identify violations on the right to health by the communities, health providers and health care systems
- Increased participation in the health sector governance by the communities

The target audiences were;

- District Health Management Team
- District Health Management Board
- Health Facility Committee/Board members
- Health Facility Committee Members
- Healthcare providers
- Grass root civil Society organizations
- Government Health Officers
- Women group representatives
- Youth group representatives
- Faith Based organizations
- PLWHAs Organizations

2.0 Climate Setting

2.1 Introductions

Participants were welcomed to the forum by Beatrice Gachambi, Program Assistant with HERAF. She thanked all for finding time to attend the forum despite their busy schedules. She invited Josphat, a public health officer in Eastern province, who welcomed the participants to the forum and requested one of the participants to lead in prayer. He then asked participants to introduce themselves.

As an ice breaker, participants were requested to introduce themselves. He then handed back to Beatrice who invited the Coordinator of HERAF, Miano Munene to introduce the team he had come with from Nairobi. These were; Winfred Lichuma from Kenya National Human Rights Commission and Jerusha Chege, a consultant with HERAF.

3.0 OUTPUTS OF THE FORUM

3.1 Strengthening Community Participation in the Health sector

Miano Munene who is HERAF's Executive Director took the participants through this session. He started by stating who HERAF is, her mission, vision and the specific goals that HERAF wants to achieve at the end of the program implementation.

He stated that HERAF is an NGO that brings together health professionals, NGOs, FBOs and PLWHA organizations to advocate for health as a fundamental human right in Kenya. It was established in 2006, as a project of Kenya Human Rights Commission (KHRC), and registered as a non-governmental organization in Kenya by the NGO coordination board in 2007.

He continued to say that HERAF's vision is to have a Kenya where health is upheld and enjoyed as a fundamental human right and the mission is to be a leading human rights organisation that promotes and empowers Kenyans to realise the right to health for all. He also stated that the overall goal is to be a visible leader in promoting, protecting and empowering Kenyans to enjoy the right to health at all times.

He then took the participants through HERAF's specific goals which include;

1. To create awareness, inform and educate health professionals, civil society and communities on health as a fundamental human right
2. To influence Kenya's health policies to guarantee promotion, respect and protection of the right to health.
3. To provide leadership among health professionals, civil society and the local masses in identifying and addressing emerging health rights issues in Kenya
4. To advocate for an efficient health financing system that ensures equity, accountability and sustainability of Kenya's health care system.

On HERAF membership, he informed the forum that they include health Professionals, Non Governmental Organizations, Organizations of People Living with HIV&AIDS (PLWHA), Faith Based Organizations, Research institutions and universities involved in health issues and Health, HIV&AIDS and human rights networks

The programs of HERAF include health rights awareness and education, evidence-based advocacy for reforms in health policies, promoting health sector management and governance as well as promoting an efficient health care financing system.

Under the heath rights awareness and education programme, HERAF provides accurate and up to date information on the right to health and other related economic, social and cultural rights. It also enables health care workers and civil society to understand and acknowledge the right to health.

On evidence-based advocacy for reforms in health policies, HERAF raises public awareness on international standards, government obligations and national legislation that promotes the right to health in Kenya. It also influences health policies, public opinions, attitudes and perceptions of the right to health at the community, district, national and

international level, and provide leadership among health workers and civil society in identifying and addressing the emerging policy gaps on the right to health in Kenya.

Under promoting an efficient health care financing system program, HERAF advances budget literacy among health care providers and civil society organizations in Kenya and advocates for transparency and accountability in planning, allocation and management of resources allocated to the health sector

Finally, in promoting health sector management and governance programme, it aims at empowering community representatives in HMB/T to represent community interests in the design and implementation of health sector programmes at the district and national level. It will also enhance the participation of civil society organizations in district and national health forums.

He explained that HERAF shall strengthen Community Participation in Health Sector Governance in Kenya through a programme funded by the European Commission. The implementing partners are Kenya human rights Commission (KHRC) and Health Rights Advocacy Forum (HERAF). He stated that it is under this programme that HERAF has called this forum to discuss about the right to health.

The Project according to Miano was muted in partnership with KHRC who is tasked with;

- Providing financial management and administration support
- Advising on financial planning and budgeting, and oversee the financial distribution including; ensuring financial procedures are followed as per requirements and standards spelt out by the donor.
- The other partner is HERAF which is the overall implementing agency for this project. He went further and revealed that HERAF will implement the proposed project with assistance from associate partners including Health NGOs Network (HENNET) and Institute of Economic Affairs (IEA)

The duration of the project is 36 months starting from January 2009 to December 2011 with a budget of 179,819 Euros

The project Locations are

1. Coast province – Kwale District
2. Eastern province –Mbeere District
3. Central Province – Nyeri North District.

According to Miano, the three project locations were because they have different geographical and socio-economic conditions which expose them to different disease conditions. Plans within the health sector should be able to address the different health issues specific to different geographical locations. The lessons learnt from each location

should be helpful in replicating similar efforts in regions with related social, economic and environmental conditions countrywide

He went on to highlight details about the project by taking the participants through the overall objective and specific objectives.

- The main objective is to strengthen community participation in health sector governance and management in Coast, Eastern and Central regions of Kenya

The specific objectives of the project are:

- To strengthen the capacity of grassroots communities to hold the government structures accountable in implementing the rights based approach to health care programmes at the district and community level
- To empower the DHMB/T to represent community interest in the implementation of health sector programmes at the district level
- To improve health service delivery by empowering communities to monitor the quality of health services provided and to demand quality services
- To advocate for transparency and accountability in planning, budgetary allocation and management of resources allocated to the community-based health facilities in order to address prevailing disease conditions

The project's target group shall include; Health Facility Committees, District Health Management Teams (DHMT), District Health Management Boards (DHMB), MOH staff working at health facilities, Civil society and the general public, Women, children, and youth will be deliberately targeted for benefits accrued from this intervention. The final beneficiaries will include General public from Eastern, Central and Coastal regions, especially women, children, PLWHA, the physically challenged, senior citizens and youth

3.2 HEALTH SITUATION IN MBEERE DISTRICT

Beatrice Gachambi, a programme Assistant with HERAF introduced the Mbeere District DMOH, Dr. Kaniaru to the participants who gave the opening remarks and an overview of the health situation in Mbeere District. He started by welcoming all the participants to the meeting and asked them to ensure that they gained from the forum organized by HERAF. He also welcomed HERAF to the District and said that he was grateful for the opportunity that HERAF gave to Mbeere District to benefit from the project. He went on to give the district profile in terms of the area coverage, the population and divisions in the area. He said that this was for the importance of understanding the area coverage in Mbeere district which would aid in the implementation process of the project. According to the presentation Mbeere District has an area of 2097km2 and a population of 203,208. The District is divided into four divisions Gachoka, Siakago, Mwea and Evurore with a population of 70,250, 40,806, 48,365 and 43,365 respectively.

Dr. Kaniaru went on to give details on the health facilities available in the district. He categorized them by type, in terms of government facilities, private as well as facilities owned/ operated by FBOs. He said that the district had 27 health facilities owned by the government and five are run by both private practioners and faith based organizations. The table below shows the breakdown of the health facilities by type as presented by Dr. Kaniaru.

Table 1: Health Facilities by type

HEALTH FACILITY BY TYPE				
Facility	**GOK**	**FBO**	**Private**	**Total**
Hospitals	2	0	0	2
H/centers	3	0	0	3
Dispensaries	22	5	0	27
Clinics	0	0	5	5
Total	**27**	**5**	**5**	**37**

He went on and informed the meeting that the top ten causes of outpatient and inpatient morbidity in the district, were; Malaria, disease of the respiratory system, intestinal worms, Pneumonia, dehydration, anemia and HIV among others as shown in annex 1. He also highlighted the health indicators in the district. This was to give a general overview of the health situation in the district, which would aid in the planning of implementation of activities in the district by the DHMT and HERAF.

He also gave the HIV/AIDS situation in the district stating the total of HIV positive people, prevalence rate as well as the health indicators in Mbeere District. According to the presentation the total HIV positive adults and children are 1295 and 273 respectively totaling to 1568 PLWHA's. The total on ARVs is 603, 537 and 66 adults and children respectively. He also gave the total population tested in year 2008 which was 18,251 and out of these 921 were positive. The prevalence rate lowered to 5.0% in 2008 from 5.1% in 2007.

In conclusion, he said that this information would be of importance to HERAF as an organization in implementation of the project's activities in the district. He appreciated the support of HERAF in the district and said that he looked forward to working together with HERAF in the implementation of the programme. He then declared the forum officially opened.

3.2.1 Plenary Discussion

Following the opening remarks and presentation on the health situation by the DMOH, Mbeere District, participants in the forum contributed and asked questions directed to the DMOH .Some of the concerns, suggestions and questions raised include;

One of the participants felt that diabetes has been left out as one of the common diseases. However, the MOH responded to this and said that it is not among the top ten diseases in the district but is in the database of the Mbeere District MOH. He was also concerned about the distance the patients had to walk to access health centers/facilities that could handle diabetes. In response to this the MOH said that there was a clinic at Siakago that is currently handling the patients from that area.

It was highlighted that there is shortage of blood in the District hospital and in response to this he said that this was due to lack of a blood bank in the Embu Provincial Hospital and also the unwillingness of people to donate blood leading to scarcity of blood

There was a concern on health facilities in relation to health rights as well as the human resource available in comparison to the patients visiting the health facilities per day were of concern. In responding to this he said that the Ministry of health initially was responsible of distribution of human resource to the health centers but at least now with the decentralization of the Ministry of health, the DMOH has the power to redistribute the available human resources for health within the district and request for more despite the fact that the process of recruitment takes long.

Winfred Lichuma, a Commissioner with KNCHR said observed it was important to disintegrate the data given by the MOH further to men, women and children for better planning and for other organizations that may need to use it for planning for health in Mbeere district. She also noted that it is meaningful to give details of the health facilities available in the district in terms of location to aid in terms of planning and accessibility for the patients.

3.3 Human Rights principles (Right Based Approach)

This was a session facilitated by Winnie Lichuma, a consultant with HERAF. This session was aimed at introducing and explaining the concept of human rights to the participants. This was a participatory session and she started by asking the participants on the basic human rights. From the contributions that they made it was clear they were well aware of basic human rights. Some of the rights mentioned by the participants include;

- Right to shelter
- Right to health
- Right to food and water
- Right to clean environment
- Right too education, life and life
- Right to security and protection
- Right to name and identity
- Right to marriage and found a family
- Freedom of expression
- Freedom of religion
- Freedom of association and movement.

On this basis the facilitator engaged the participants in a discussion as to whether any of the above rights was superior to any another. Participants felt that some rights were superior to others. After a heated up discussion, the facilitator explained to the participants that none of the rights was more superior to any other but they are all related to each other and complement each other as they are exercised. She went on to explain that all human rights are equally important. She highlighted the 1948 Universal declaration of human rights which makes it clear that human rights of all kinds be it economic, political, civil or cultural and socio rights are equal validity and importance. She then stated that human rights are also indivisible and interdependent. The principle of their indivisibility recognizes that no human rights in inherently inferior to any other. Economic, social and cultural rights must be respected, protected and realized on an equal footing with civil and political rights. The principle of their interdependence recognizes the difficulty of realizing any one human right isolation. Taken together, the indivisibility and interdependence principles mean that offers should be made to realize all human rights together, allowing for prioritization as necessary in accordance with human rights principles.

The facilitator informed the participants that human rights are universal legal guarantees that protect individuals and groups against actions and omissions that interfere with the fundamental freedoms, entitlements and human dignity. She went on to say that human rights laws oblige governments and other duty bearers to do certain things and prevent them from doing others.

She went on to inform the participants that rights are guaranteed to all human beings under international treaties without any discrimination on grounds of sex, race, language, political or other opinion, national or social origin. Rights guaranteed also include the right to life, freedom from slavery, equal protection of the law, right to nationality as well as the right to the highest attainable standards of health, right to food, water, food, clean environment etc.

She explained that countries sign or ratify to international treaties and it is expected that they domesticated the treaties as national laws or policies. Each of these treaties has established a committee of experts to monitor implementation of the treaty provisions by its state parties. Such treaties include:

- International Covenant on Civil and Political Rights ICCPR (1966)
- International Covenant on Economic, Social and Cultural Rights ICESCR (1966)
- International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) (1965).
- Convention on Elimination of All Forms of Discrimination Against women. (CEDAW) (1979).
- Convention on the Rights of the Child. (CRC) (1989).Convention Against Torture and other Cruel, inhuman Degrading Treatment or Punishment (CAT) (1984)
- International Convention on the Protection of the Rights of All Migrant workers and members of their Family (MWC) (1990)
- Convention on the Rights of Persons with disabilities (CRPD) 2006.

She went on to say that rights protected have categories such as:

- Rights of indigenous peoples and minorities.
- Prevention of discrimination.

- Rights of women.
- Rights of the child.
- Rights of older persons.
- The right of self-determination
- Rights of persons with Disability
- Social welfare, progress and development.
- Marriage
- Right to health
- Right to work and to fair conditions of employment
- Freedom of Association
- Rights of Migrants
- Nationality, Stateless, Asylum and Refugees
- War crimes and Crimes against Humanity, including Genocide
- Humanitarian Law
- Slavery, Slavery-like practices and forced labour.

She explained to the participants that human Rights come with obligations. Obligations are generally of three kinds: to respect, to protect and fulfil human rights. To respect human rights means simply not to interfere with their enjoyment, to protect means to take steps to ensure that the third parties do not interfere with their enjoyment and to fulfil means to take steps progressively to realize the right in question. Examples include;

- Violations or lack of attention to human rights can have serious health consequences.

- Health policies and programmes can promote or violate human rights in the ways they are designed and implemented.

- Taking steps to respect, protect and fulfil human rights can reduce vulnerability and the impact of ill health

On the right to health, the facilitator said that it endows each person with an equal claim to timely and appropriate health care, as well as the underlying conditions that foster good health, such as access to safe water, adequate nutrition, safe housing and access to accurate information among others. The international community elaborated the right to health in the document “General Comment 14”; it outlines four specific criteria that could be used through out the world to further understand what governments must do to ensure the realization of the right to health for its citizens. These are;

- Availability-functioning public health and health and health-care facilities, goods and services as well as programmes have to be available in sufficient quantity.

- Accessibility- services must be accessible to everyone without discrimination.

- Acceptability-All health services and goods must respect medical ethics and be sensitive to gender. It must respect confidentiality.

- Quality-Health facilities, goods and services must be scientifically and medically appropriate and of good quality

She then went on to relate the principle of Freedom from discrimination and Health and said that:

- It targets the vulnerable and marginalized in societies.
- Overt or implicit discrimination violates the fundamental human rights principles and always lies at the root of poor health status.
- Discrimination manifests itself in a complex variety ways for example violence against women, children, PLWHA's, physically challenged among others.
- Preferential treatment in reasonable circumstances does not amount to discrimination.
- Public health practices are heavily burdened by the problem of inadvertent discrimination-mostly relying on assumptions. This means that the public suffer due to presumptuous decisions made on their behalf without them being consulted.

3.3.1 Right to Health in the context of Kenya

The facilitator stated that ICESCR[1] imposes binding obligations on all state parties and under international law, a state has to implement these obligations in good faith. She explained that upon ratification/signing of an international treaty/covenant, the state usually amends its domestic law so that it is in conformity with the covenant. After the ratification the state has an obligation to ensure, new laws conform to the covenant. Kenya has ratified various international and regional instruments that provide the right to health and non-discrimination. i.e. ICCPR[2], ICESCR, CRC,[3] CEDAW[4], ICERD[5], and the African Charter among others. However, Kenya has to strife to keep to the health related goals it has committed itself to i.e. MDGs, UNGASS for children and HIV and AIDS, etc.

She went on to say that the GOK has attempted to operationalize the commitments through various policies geared towards achieving broad based sustainable improvement in the welfare of Kenya through the National Poverty Eradication Plan, the PRSP and the Vision 2030.

---

[1] International Covenant on Economic, Social and Cultural Rights

[2] International Covenant on Civil and Political Rights

[3]Convention on the Rights of the Child

[4]Convention on Elimination of All Forms of Discrimination Against women

[5] International Convention on the Elimination of All Forms of Racial Discrimination

She then highlighted the emerging challenges in the Kenyan health sector which include: Poverty and Hunger, maternal death, child mortality, combating HIV and AIDS, Malaria and other diseases, environmental issues and water and sanitation.

In conclusion she said that most laws and policies in Kenya are outdated and require review. She recommended that the government and other agencies should jointly work towards fulfilment of the right to health and that rights-based approach which will insist on participatory approach and empowerment will be the recommended model. She noted that the waiver of maternity fees is a positive move by the government in effort to curb infant mortality. The rights-based approach that will insist on participatory approach and empowerment of communities will be the recommended model to use and that we need to convince the 10th parliament that we must include ESCR into the constitution during the proposed review of the constitution

3.3.2 Right-Based Approach to Health

The facilitator introduced to the participants the concept of Right Based Approach to Health. She started by stating that approaching the issues of sound public health policies through the lens of human rights, and the right to health in particular is the concept of right based approach. She went on to explain that this approach transforms the traditional discourse on health in two fundamental ways;

- It changes the government's responsibility in terms of the health of its population.
- It changes the citizen's responsibility in terms of demanding that the government meets its human rights obligations.

The facilitator then said that the RBA[6] recognizes poverty as an injustice and include marginalization, discrimination and exploitation as central causes of poverty. She explained that in the RBA, human rights are described as:

- Universal legal guarantees protecting individuals and groups against actions and omissions that affect their freedom and human dignity.
- Basic minimum standards based on human needs.
- Universal and inalienable i.e. all people are born with the same human rights everywhere, at all people are born with the same human rights everywhere, at all times, and they cannot be taken away or given up.
- Indivisible and interdependent, i.e. all rights are equally necessary for human life and dignity.

3.3.2.1. Rights Holders and Duty Bearers

[6] Right Based Approach

The facilitator explained that in the RBA, there are rights holders and duty bearers. She went on to give an example of the health system whereby the right holders are the patients or communities seeking health services in the health facilities whereas the health care providers and the government are the duty bearers.

She then stated that human rights claims always have a corresponding duty bearer. The central dynamic of RBA is thus about identifying root causes of poverty, empowering rights-holders to claim their rights and enabling duty-bearers to meet their obligations. Duty- bearers are those that bear the obligations and duties to respect, protect and fulfill both moral and legal claims. Duty -bearers can thus be either legal duty-bearers or moral duty bearers. The legal duty-bearer is first and foremost the national State and its institutions. In the human rights framework, it is in the first instance the State that has the principal obligation to respect, protect and fulfill rights.

She explained that, State institutions and non-State institutions like CSOs that offer any service within a community then become duty-bearers. Moral duty-bearers encompass everyone who has duties to their community and responsibility to strive for the promotion and observance of rights. In moral terms, human rights are claims that we all have against everyone else.

She then stated that a rights-holder is entitled to rights, to claim rights, to hold the duty-bearer accountable and has a responsibility to respect the rights of others. Consequently those who have the obligation to respect, protect, and fulfill the rights-holder are duty bearers.

She concluded by saying that the communities should claim for their rights as the claim holders and hold the duty bearers accountable but again this is dependent on the resources available whereas the health care providers should provide health care services to the communities to their best of ability and as much as the resources allow.

3.3.2.2. RBA Principles

The facilitator then stated the principles of a rights based approach as:

- The universality and inalienability of rights.
- The indivisibility and interdependence of rights.
- Inclusion and non-discrimination.
- Participation and empowerment.
- Transparency and accountability
- Aim to achieve sustainability.
- Focus attention on the poor, marginalized and most vulnerable.
- Increase partnerships and community participation.

3.3.2.3. Value added with RBA

She then stated that a rights based approach adds value in that:

- It promotes justice, equality and freedom and tackles power issues.
- It offers a framework to address the problems of the poor and the most vulnerable and marginalized groups.
- It holds people who are in power accountable to fulfill their responsibilities toward those with less power.
- It leads to more efficient progress by empowering people and communities to demand their rights and hold people accountable.
- It leads to a holistic approach of human rights principles that should change methods of working.
- The process and the outcomes are equally important. It will not be a matter of changing what we do, but rather a question of how we do it'.
- If properly applied in all phases of programme development and management, it empowers people to make decisions about issues that affect their lives, other than being passive recipients.
- It leads to better analyzed and more focused interventions that are strategic. NGOs in health sector will identify gaps in the health policy formulation and implementation process.
- Programmes will benefit from enhanced ownership by the people and enhance sustainability.
- NGOs will identify clear bench marks and indicators. This will ensure equality in provision of health services.

In conclusion, she emphasized that one should always remember the guiding principles in HRBA[7] programming that are defined are:

- Participation,
- Accountability
- Non-discrimination
- Empowerment
- Linkages to human rights standards.

The process to guide Rights Based Approach includes; participation which affirms that people are entitled to be consulted and have a say in the decisions that affect them. It does

[7] Health Rights Based Approach

not mean that people are entitled to determine the decision but are consulted and the consultation must be meaningful. It aims to achieve shared understanding of development process.

RBA also includes giving people information and this means that people have a right to essential information on matters that concerns them. This right underpins demands for transparent decision-making and public disclosure of information levels. It is also a vital element of accountability, since officials cannot be held accountable for acts and decisions that remain disclosed. With information, people are empowered and this means that they are able to make informed decisions that are of benefit to them.

Association and Expression is also included in the RBA process and it comes with the right to meet together to exchange information and express opinion is similarly essential. It supports the effective exercise of the right to be consulted, informed, and express opinions. It emphasizes that people have a right to express their opinion on matters of concern to them. It also includes the right to dissent and acknowledges that a person who cannot voice her point of view, because she is prevented from speaking or deprived of the tools she needs to form an opinion, is disempowered

In conclusion to this session she emphasized on the interdependence and interrelatedness of Rights. She said that rights are interdependent and mutually supportive and that none of these rights can be properly exercised in isolation.

3.3.3 Plenary Discussions

After the session by the facilitator, participants in the forum made contributions, expressed their concerns and asked questions. Most of the concerns and questions were related to the rights of duty bearers and how they would agitate for their rights. These were:

- A participant was concerned about policies and programmes being contextualized at the grass root and specifically on the health resource chatter information in Hospital premises that may not be of help to the community. He went on to state that very few people at the grassroot communities were able to read and understand what was indicated on the chatter. In response to this the participants felt that it was of concern and information on the chatter should be simplified and also translated to either Kiswahili or the local language and disseminated to the communities for it to be meaningful to the community who are the key targets of the chatter.
- A participant asked about the rights of health workers in regard to overworking of staff in health centers, are staff aware of their rights and the compensation that comes with it. Heath staffs in the forum were encouraged to read the HRH strategic plan 2007/08 – 2009/10 to know what it states about them and also the workplace policy so as to know what is required of them as they give services to the community.
- A participant was concerned about the long time taken for communication from the grassroots to reach to the relevant authorities at the MOH at the national level. This was in reference to the Annual Operational Plans which come from the

Bottom to Top management but are never worked on. Participants felt that the government should decentralize some of the decision makers to the level of district rather than the ministry to facilitate in faster decision making.

- A participant stated that some of the problems experienced in the health sector are as a result of the failures in the health system in the country. Like for instance, accessibility of health facilities by patients in terms of how far patients have to walk in order to seek for treatment. The ideal distance is a radius of 5 kilometers. Participants felt that the health centers were very far from some of the community members and may sometimes keep the community members from accessing the health services required in time.
- A participant felt that sometimes the poor think that the provision of healthcare is a favor done to them. In response to this, the facilitator said that this called for civil education on health as a right and not a favour at the grassroots for community members which should be consistent and done time and time again.
- On priorities in the health system, the participants felt that the government lacks priorities especially when it comes to healthcare. In the Abuja agreement that Kenya is a signatory to, it stated that 15% of the national budget should be allocated to health but this is not the case in Kenya, it is at 8% and may even go lower to 7%. HERAF was asked what they were doing about this and in response to this Miano said that HERAF inputs into the budget process through the submissions made during the planning phase of the budget process. However, he said that at times the submissions are taken into consideration while at other times they are not. Participants felt that health is of paramount importance to a working nation, which, in return becomes productive and thus should be given priority compared to other sectors in government.
- There was a concern that the rich who hardly understand what the poor man in the community is going through are the ones who make health policies. This ends up oppressing the poor. A recommendation was that there should be devolution of health service delivery so that it uses a bottom up approach, which will involve the communities on the ground. In response to this, the facilitator said that the government has done this through devolved funds such as CDF, LATF, Bursaries and HIV/AIDS money through the CACCs[8]. This has worked to some extent and thus can also influence policies in a bottom up approach if used appropriately.
- The participants felt that the government should educate the public on basic health rights and provide information on the same to the citizens to enable them make informed decisions and to ensure that they have access to the right to information.
- A participant noted that health care rights programmes focus mainly on women and children and leave out the men who also have health issues to deal with. After a discussion, it was agreed that men should also come out and speak about their issues so that they are also included in the various programmes.

In concluding this session, the facilitator challenged the participants to adapt the principle of ownership. She said that this helps in lobbying for health rights since

[8] Constituency AIDS Control Committees

there is a greater and combined voice of many people and thus it is easier to be heard by the policy makers. She went on to say that it is fundamental for people to know that human rights are not priviledges or favors done to them by the duty bearers but they should understand that they are entitled to these rights. However, she noted that it is also important to note that rights come with responsibilities and thus ensures that the rule of law is upheld.

4.0 Way Forward

This was a session led by Miano Munene, HERAF's Executive Director whereby he asked the participants to brainstorm on the way forward. The issues identified as way forward are:

1. HERAF in conjunction with the MOH[9] office should carry out a Mapping/ situation analysis to identify health rights issues affecting the community and the health workers, the distance between the health facilities and how accessible they are to the community.
2. There is need for a situational analysis to find out whether the healthcare facilities are well equipped with human resource and equipment needed in delivery of health care services.
3. The MOH staff working in health facilities should know their rights through ways such as reading the HRH strategic plan 2007/08 – 2009/10 that highlights on the rights of workers as the duty bearers.
4. Health workers should ensure the information they have goes down to the community members who would support them to agitate for the right services at the health cares. This means that the service providers who are the health workers should share their challenges and limitations with the community members at the health centers so that they come together as one voice and agitate for their rights using correct information without the service providers being victimized. This will ensure that health centers have the provisions needed to give the services.
5. Participants were encouraged to share the information and knowledge gained from the forum with their colleagues as well as the community members and other stakeholders in order to create awareness at the grass root level since they were in the forum as representatives of the communities.

5.0 Conclusion

In conclusion, the participants felt that it was important for the partnership with HERAF to continue and that more community members should be trained on health rights and the responsibilities that come with the rights. HERAF's executive Director reminded them

[9] Medical officer of Health

that they are either duty bearers or right holders and thus should carry out their duties as expected and agitate for their rights where required and necessary. He urged them to support those who agitate for their rights rather than watch them from afar in order to offer moral support to them and strengthen their voice in the fight for their rights.

While making the closing remarks, Mbeere DMOH[10] thanked HERAF for organizing such an informative forum and said that he looked forward to more partnership and collaboration with HERAF. He also thanked all the participants for their valuable participation in the forum and asked them to share what they had learned with other health stakeholders in the district.

6.0 Evaluation

At the end of the forum, participants evaluated the forum and their evaluation included:

- They felt empowered knowing their rights to health as service providers and also recipients of health services.

---

[10] District Medical Officer of Health

- They now had a clear understanding of human rights in relation to health
- They liked the participatory approach of the forum whereby they were involved in the discussions and hence appreciated the fact that it was a community dialogue forum
- They were now aware of how to agitate for rights as duty bearers and rights holders.
- They felt that the forum should be carried out at divisional level rather than district level so as to reach more community members.
- They wanted more time to be allocated for the forum in future so that more stakeholders on the ground are reached.
- There is need to Capacity build grass root organizations like women groups, CHW's, Chiefs, PLWHAs, CBOs, FBOs, Youth Groups on Human Rights and how they can pass the information on Health rights to the communities.
- They also liked the setting of the forum whereby the health managers, health care providers and the health recipients were brought together to discuss the various issues affecting their realization to the right to health in the area.

ANNEX 1: HEALTH INDICATORS IN MBEERE DISTRICT

TOP TEN CAUSES OF OUTPATIENT MORBIDITY

1. Malaria -140,194
2. Disease of the respiratory system-81,806
3. Intestinal worms -26,875
4. Pneumonia -16053
5. Disease of the skin -20,511
6. Diarrhea -8,653
7. Rheumatism -4,341
8. Accidents -6,165
9. Eye infection -7,718
10. Typhoid -5,039

TOP TEN CAUSES OF INPATIENT MORBIDITY

1. Malaria
2. Pneumonia
3. URTI
4. Anemia
5. ARI
6. Typhoid(suspected)
7. Diarrhea
8. PTB
9. Dehydration
10. HIV/AIDs

- Population Growth Rate =2.3
- Under Five Mortality Rate =74/1000
- Fertility Rate =6.6/woman
- Maternal Mortality Rate =127/100,000
- Crude Death Rate =10.7/1000
- Infant Mortality Rate =42/1000
- Crude Birth Rate =47.7/1000
- Life Expectancy :

  Male =53

Female =53

- Immunization coverage =84%
- Underweight =8.3%
- Poverty levels =60%
- Malaria case fatality rate =0.16%
- HIV prevalence rate =5.0%

ANNEX 11: LIST OF PARTICIPANTS

MBEERE DISTRICT COMMUNITY DIALOGUE FORUM HELD ON 23RD APRIL 2009

	Name	Organization	e-mail contact	Telephone number	Address for future invitation
1.	Dr. S.M. Kaniaru	MOH Mbeere	mohmbeere@yahoo.com	0722336710	Box 81 Siakago
2.	Muriithi K. Henry	MOH Mbeere	Mkhenry2008@yahoo.com	0720782964	Box 81 Siakago
3.	Josphine R Miriti	MOH Mbeere	jossymburia@yahoo.com	07220492415	Box 81 Siakago
4.	Peris Njeri	MOH Mbeere		0729373145	Box 81 Siakago
5.	Keziah Mwangi	MOH Mbeere		0723324486	Box 81 Siakago
6.	Zablon Gitonga	CCF Mbeere	zabgitonga@yahoo.com	0721325164	B0x 182 Shiara
7.	Rhoda R Ndwiga	Kathanje Dispensary		0735174963	c/o Box 81 Siakago
8.	Edward N James	Riandu dispensary		0720989831	c/o Box 81 Siakago
9.	Lucy N Mwaniki	Kavonduri h/centre		0721371345	Box 62 Embu
10.	Joyce M Wambua	Rwika		0723660040	Box 183 Kubukubu
11.	John.N Mbogo	Kathanje Dispensary		0725787973	Box 46 Siakago
12.	Lydia Mwendia	Kathanje Dispensary		0724223046	Box 46 Siakago
13.	Anna Mati	Kirie Dispensary		0723262630	Box 26 ishiara
14.	Joyce Mwaniki	Kirie Dispensary		0720311817	Box 95 siakago
15.	Rose Njoka	Kirie Dispensary		0726537511	Box 81 Siakago
16.	Niceta Wanjiru	Treasurer Dispensary		21058728	Box 356 Siakago
17.	Gladys Muthoni	Kiritiri Dispensary			Box 22 Kiritiri
18.	Moffat Njeru	Compassion international	Roony-ndaru@yahoo.com	0721882657	Box 72 ishiara
19.	Eunice Njeru	Compassion international	njeru@yahoo.com	0721808560	Box 1017 Embu

20.	Christine Nyawira	Kiambere dam disp			Box 58 Kiritiri
21.	Nicholas Muringi	Dynamic youth		0715779016	Box 2 Ishiara
22.	Francis Njeru	Mbeere Youth group		0726485102	Box 71 Siakago
23.	Margaret Muthoni	Mbeere PLWHIV		0726631781	Box 5 Siakago
24.	Gilbert Ndwiga	Mbeere PLWHIV		0729686459	Box 71 Siakago
25.	Sarah Thara	Mbeere PLWHIV		029686459	Box 71 Siakago
26.	Ireri Mathew	MOH Mbeere	mathewmbake@yahoo.com	0721903882	Box 781 Siakago
27.	Josphat Mutua	MOPH$S	Jmmutua@yahoo.com	0721568299	Box 1905 Embu
28.	Dickson Njiru	Kiambeere dam disp		0727629862	Box 269 kiritiri
29.	Sicily Mureithi	SWAK Embu	Cicily04@yahoo.com	0722956201	Box 2515 Embu
30.	Ndege Cyrus	Mbeere MOH	MOHmbeere@yahoo.com	0712138902	Box 81 Siakago
31.	Caser Njeru	IshiaraSDH		0728312113	Box 125 Ishiara
32.	Michael N.Mareri	Kiambere d. disp		0721310434	Box 81 Siakago
33.	James Nduma	RGC church Kiritiri		0724808115	
34.	Peter kariuki	FGCK Kiritiri		0721714425	
35.	Abishag Njoki	Kiritiri Dispensary		0726040639	
36.	Gacheri Muturi	Zingatia maisha	Ggmuthuri06@yahoo.com	0721516813	Box 1905 Embu
37.	Peterson Njagi	Siakago BHMB		0734469096	Box 164 Siakago
38.	Priscah Njuki	Siakago BHMB		0723931713	Box 145 Siakago
39.	Jeremiah Kasungi	DMOH office Mbeere	kasunginjere@yahoo.com	0729635454	Box 81 Siakago
40.	Mary Kiringa	Siakago HMT		0725628953	Box 81 Siakago
41.	Mary Nthiga	Kiambindu		0729173824	Box 106 Ishiara
42.	Benard Mwinzi	Karurumo			
43.	David Njagi	DHMT-Mbeere			Karurumo H/centre

44.	Monica Mbogo	MOH-Mbeere		0721661018	Box 81 Siakago
45.	Evans Nthumbi	DHMT-Mbeere		0738240144	Box 81 Siakago
46.	Dr. Okemwa	DHMT-Mbeere	Joe01okemwa@yahoo.com	0721307721	Box 81 Siakago
47.	Paul Muhoro	Riandu dispensary		0721436519	Box 902 Embu
48.	Beatrice Gachambi	HERAF	bgachambi@heraf.or.ke	0723634225	Box 100667-00101 NBI
49.	Jerusha Chege	HERAF	jmchege@yahoo.com	0722445181	2989 00100 Thika
50.	Fr.Peter Moti	Catholic church konymamboro		0710172759	Box 1499 Embu
51.	Rebecca Wanjiru	PMCTC		0722119528	Box 60 Siakago
52.	Miano Munene	HERAF	mmiano@heraf.or.ke	0722828880	Box 100667-00101 NBI
53.	Winfred Lichuma	KNCHR	wlichuma@yahoo.co.uk	0721952322	Box 74359-00200 NBI