

# **Challenges Facing the Health Workforce in Achieving the Millennium Development Goals and PEPFAR Targets in Kenya**

Kenya Health Rights Advocacy Network (KHRAN)  
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## List of abbreviations:

<b>AIDS:</b>	Acquired Immunodeficiency Syndrome
<b>APHIA II:</b>	AIDS, Population, Health Integrated Assistance Programme
<b>ART:</b>	Antiretroviral Therapy
<b>CCC:</b>	Comprehensive Care Centre
<b>CDF:</b>	Constituency Development Fund
<b>CHEW:</b>	Community Health Extension Worker
<b>CPD:</b>	Continual professional development
<b>CSO:</b>	Civil Society Organization
<b>DHMT:</b>	District Health Management Team
<b>DMO:</b>	District Medical Officer
<b>ERS:</b>	Economic Recovery Strategy
<b>GDP:</b>	Gross Domestic Product
<b>GoK:</b>	Government of Kenya
<b>HIV</b>	Human Immunodeficiency Virus /
<b>HRH:</b>	Human resources for hHealth
<b>IMF:</b>	International Monetary Fund
<b>KEMSA:</b>	Kenya Medical Supplies Agency
<b>KEMRI:</b>	Kenya Medical Research Institute
<b>KEPH:</b>	Kenya Essential Package for Health
<b>KHRAN:</b>	Kenya Health Rights Advocacy Network
<b>KMA:</b>	Kenya Medical Association
<b>MCH:</b>	Maternal and child health
<b>MDG:</b>	Millennium Development Goal(s)
<b>MOH:</b>	Ministry of Health
<b>NASCOP:</b>	National AIDS and STD Control Programme
<b>NGO:</b>	Non-governmental organization
<b>NHSSP II:</b>	National Health Sector Strategic Plan
<b>NSSF:</b>	National Social Security Fund
<b>OVC:</b>	Orphans and vulnerable children
<b>PEPFAR:</b>	President's Emergency Plan for AIDS Relief
<b>PHC:</b>	Primary health care
<b>PHMT:</b>	Provincial Health Management Team
<b>PHO:</b>	Public Health Officer
<b>PHT:</b>	Public Health Technician
<b>PMO:</b>	Provincial Medical Officer
<b>PMTCT:</b>	Prevention of mother-to-child transmission
<b>RH/FP:</b>	Reproductive health/family planning
<b>SAP:</b>	Structural Adjustment Programme
<b>SWG:</b>	Sector Working Group
<b>TNA:</b>	Training needs assessment
<b>USAID:</b>	United States Agency for International Development
<b>VCT:</b>	Voluntary counseling and testing
<b>WHO:</b>	World Health Organization

## **1.0 Background**

Kenya's health gains of the 1980s and 90s have begun to reverse. According to the World Health Organization (WHO), the country has recently witnessed a general deterioration in health indicators due to rapid population growth, child nutrition problems, poverty, HIV/AIDS, acute respiratory infections, malaria, diarrhea, and poor quality health facilities and services.

In September of 2000, Kenya signed the "Millennium Declaration" at the United Nations, a document outlining an unprecedented promise to end extreme poverty throughout the world by the year 2015. Leaders from both developed and developing nations who signed the declaration committed themselves and their governments to work together to reach eight critical, time-bound goals known as the Millennium Development Goals (MDGs), including reducing child mortality, improving maternal health, and combating HIV/AIDS, malaria and other diseases. However, it will be very difficult for Kenya to achieve the MDGs given the current health and economic situation.

Similarly, through the President's Emergency Plan for AIDS Relief (PEPFAR), Kenya plans to support 250,000 antiretroviral therapy (ART) patients, reach 3 million voluntary counseling and testing (VCT) clients, and avert 37,500 HIV infections through prevention of mother-to-child transmission (PMTCT) for 539,286 clients by the year 2008.

In order to reach these MDGs and PEPFAR goals, Kenya must scale up basic health care services, which in turn means realigning and utilizing the current human resources for health (HRH) more efficiently and effectively. Currently, however, there is a severe shortage of health workers in all cadres to serve the overwhelming and increasing population in need of ART, PMTCT and VCT services.

If the current freeze on appointments in the public health sector is in place through 2008 for the staff categories providing ART, PMTCT and VCT services, Kenya will not be able to achieve the MDGs or reach the PEPFAR targets. While there is an overall shortage of health workers in the public sector, distribution of those currently employed is another obstacle. The distribution of skilled health professionals is heavily skewed towards urban areas, while rural areas suffer from a severe shortage of health workers serving a large and widespread population.

However, the health worker shortage in Kenya is not due to a lack of training capacity, as is the case for many other African nations facing similar shortages. Currently in Kenya, thousands of trained medics remain unemployed or underemployed, and are eager to take up full time positions.

Due to the severity of the health workforce crisis, and the growing pool of trained health workers who remain unemployed, the Kenyan government has continually announced that health spending will increase substantially, including recruiting more health professionals to the public sector. Yet despite these announcements, international lending institutions have placed ceilings on wage expenditures in Kenya in order to ensure macroeconomic stability in borrowing nations.

As Kenya strives to achieve the MDGs and PEPFAR targets, there are many challenges facing the health workforce, both a result of the Government of Kenya's previous policies in the health sector, and the policies of development partners from across the globe. KHRAN organized a workshop in Embu, Eastern Province to explore these challenges and forge a way forward for district health workers to engage in health rights advocacy, utilizing their unique experience and expertise from the frontline of the fight against HIV/AIDS.

## **2.0 Climate Setting**

### **2.1 Introductions and Participants' Expectations**

Lucy Simiyu, Kenya Health Rights Advocacy Network Program Officer, welcomed participants to the forum, and invited each to share their names, organization and expectations for the workshop. Some of the participants' expectations included:

- To improve their understanding of the links between HIV/AIDS and human rights;
- To improve knowledge and understanding of the human right to health;
- To learn more about the work of the President’s Emergency Plan for AIDS Relief (PEPFAR) in Nyanza Province;
- To learn how health professionals can become involved in health rights advocacy;
- To understand the advocacy priorities for health workers in Nyanza Province;
- To further understand the legal rights of vulnerable groups, such as children; and
- To learn how to work towards strengthening women’s rights.

## 2.2 Brief Presentation about KHRAN

To enlighten the participants about the forum and the organization behind the campaign, KHRAN program officer, Lucy Simiyu, made a brief presentation about the Network. The presentation covered a short history of KHRAN, including its establishment in April 2006 after a series of consultative forums among CSOs and other key stakeholders in the health sector with support from Physicians for Human Rights (PHR), USA.

She highlighted the KHRAN Vision, Mission and Goal:

*Vision:* A Kenya where health is recognized as a fundamental human right, with access to equitable, affordable health services for all.

*Mission:* To monitor and advocate for the provision of equitable health services through community and health provider partnerships, *utilizing a rights-based approach.*

*Goal:* To provide a forum for collaboration and partnerships among health professional organizations, NGOs and other Civil Society Organisations advocating for recognition of health as a fundamental human right in Kenya. He also discussed the KHRAN Strategic Objectives and activities

Ms. Simiyu informed the group that KHRAN is hosted by Kenya Human Rights Commission (KHRC) through a Memorandum of Understanding (MoU). The Network is run by a steering committee under the chairmanship, while the day to day functions of the Network are overseen by the Coordinator. Currently participants were informed that the Network has 3 members of staff.

Ms. Simiyu concluded the presentation by making an appeal to participants to join KHRAN and spearhead the various campaigns. She emphasized that the membership is open to CSOs and other key stakeholders involved in health and HIV&AIDS from a rights-based perspective. These include:

1. Health Professional Bodies and Associations
2. Non Governmental Organizations
3. Organizations of People Living with HIV&AIDS (PLWHA)
4. Faith Based Organizations (FBOs)
5. Research institutions and universities involved in health issues
6. Health, HIV&AIDS and Human Rights Networks

## 2.3 Workshop Objectives

The objective of the workshop was to deliberate on challenges facing the health workforce as Kenya works towards achieving the MDGs and PEPFAR targets by 2015. Specifically, the forum aimed to:

- 1) Discuss the challenges and hindrances facing health professionals as Kenya strives to achieve the MDGs and PEPFAR targets;
- 2) Provide health professionals an opportunity to make suggestions on how best to improve their work conditions in order to facilitate the country to achieve health for all by 2015 and the MDGs.

## 2.4 Opening Remarks by Kisumu KMA Chair

Dr. Stephen Okeyo, chair of the Kenya Medical Association, Kisumu branch, provided brief opening remarks. He thanked participants for finding time in their schedules to attend this workshop, and urged participants to address the concerns and needs of vulnerable populations in Kenya who suffer from limited access to health services. To conclude his opening remarks, Dr. Okeyo urged participants to use this workshop as a platform for deliberate action, and to examine what they can do as health professionals to change the scenario of disparity in health care across Kenya.

## **2.5 Official Opening Remarks by Medical Superintendent, New Nyanza Provincial Hospital**

Dr. Juliana Otieno, Medical Superintendent at New Nyanza Provincial Hospital, provided the official opening remarks. She began by highlighting the role of health workers in advocating for “health for all” in Kenya, and noted that the introduction of PEPFAR funds had greatly increased Kenya’s ability to treat and care for people living with HIV/AIDS. However, she also highlighted some of the challenges facing health professionals as they work with government and donors to provide health services. These include:

- Lack of quality training in human rights and legal recourse for victims of human rights violations;
- Lack of guidelines for addressing emerging diseases in Kenya, such as Rift Valley Fever;
- Lack of clarity on policy and Ministry of Health guidelines;
- Insufficient access of health workers to information from the Ministry headquarters;
- Migration of health workers outside of Kenya, or “Brain Drain;” and
- Insufficient capacity to use new and improved technology in the health setting.

However, Dr. Otieno also provided a way forward for participants, noting that while there are serious challenges facing the health workforce, there are also opportunities to overcome these challenges through effective collaboration and advocacy. Some of the areas health workers must address to effectively overcome these challenges include:

- Improving networking among health workers, continually sharing experiences and moving forward together;
- Encouraging non-governmental organizations to approach health workers, rather than vice versa;
- Improving sharing of information and experiences among health workers, donors, and policy makers; and
- Building a relationship with KHRAN to keep involved in health rights advocacy and ensure that the needs of patients and providers in Nyanza Province are adequately addressed.

Dr. Otieno thanked KHRAN for the opportunity to open the forum, and excused herself to return to her daily duties at the New Nyanza Provincial Hospital.

## **3.0 Outputs of the Forum**

### **3.1 Keynote Address on Challenges Facing Health Professionals and Kenya Strives to Achieve the Millennium Development Goals and PEPFAR Targets**

Professor Dan Kaseje, Professor of Public Health at Great Lakes University of Kenya, provided the keynote address. He began by highlighting the major improvements in health made during the 1960s and 70s, when there was enhanced recognition of the link between health and development. This led to affordable and accessible health interventions and socioeconomic development which effectively reduced mortality and increased life expectancy.

However, several factors have caused these impressive gains to be reversed in the 1980s and 90s, such as:

- The growing dependent population in Kenya, including children, the chronically ill, and the elderly;
- The growing disparity between counties in access to health technology;

- The often inadequate skills mix of health professionals; and
- The imposition of solutions formulated outside of the Kenyan context, which are often too simplistic to make an impact in the local context.

Furthermore, Professor Kaseje highlighted the many different epidemic-demographic challenges facing the Kenyan population, which compound the reversal in health trends. These include the growing population of chronically undernourished Kenyans, frequent famines, high fertility, emergence of new diseases and the re-emergence of old diseases (such as polio), increasing drug resistance, the spread of the HIV/AIDS pandemic, health systems which are ill-equipped to cope with the demands of chronic care and the devastatingly high cost of health care as a result of widespread poverty.

Professor Kaseje continued by noting the policy challenges that have impeded Kenya's ability to address the above-mentioned epidemic-demographic challenges. These include:

- The debt crisis of the late 1970s and early 1980s, which resulted in the imposition of Structural Adjustment Programmes (SAPs) that severely constrict social spending in Kenya;
- The increasing cost of health care means that out-of-pocket expenses on health care far outstrip public expenses, which leads to the majority of health care happens at the household level, which remains unregulated;
- Private sector (household expenses) account for 77% of the total health care expenses in Kenya, and these resources tend to be directed to tertiary care, which has a negative effect on the provision of PHC; and
- The emergence of health care as a private good available only to those who can afford it, limiting the access of the poor and vulnerable to health services, even though they are the population who suffers the highest burden of disease.

According to Professor Kaseje, the Kenyan government (GoK) has tried to reform the health sector to address these emerging epidemic-demographic and policy challenges. Their efforts include devolution of power and decentralization of governance and management, diffusion of the authority nexus, distribution of resources to the district level, attempts to strengthen the linkages between the community and the health system, and the development of the essential package of care for all ("6 by 6" initiative). They have also introduced cost-sharing, which has had an extremely negative impact on access to health services for the poorest and most vulnerable Kenyans.

The limited access to health services throughout Kenya is made worse by several factors, including deepening poverty, poor infrastructure, households bearing the bulk of care, ignorance of traditional systems of care, and delayed care-seeking, which results in even higher costs of care because diseases are far-advanced. Furthermore, there is a drastic shortage of health workers in Kenya, which limits the health workforce's ability to provide services, and further decreases access to health services. The few health workers that Kenya does have in the public sector are responsible for *all* tasks, from service provision to management to financial duties; 83% of health professionals are service providers, who must then take on extra tasks. This limits the focus on preventing disease in the health setting, which has contributed to the reversal of health trends.

However, Professor Kaseje provided a way forward for participants, and made several recommendations for effective collaboration between health workers and policy makers. These include:

- Expanding partnership with the community and systems of traditional healing, which will in turn expand access to health services and relieve pressure on the conventional health system;
- Promote dialogue between practitioners, the community, and experts in the field of public health, basing effective interventions on the capacity and areas of influence of each partner;
- Develop a model for health care where the client and the health professional can come together to discuss the best and most effective way to deliver health services, reducing the dichotomy between provider and patient; and

- Develop a monitoring mechanism that is based on information, so that stakeholders can assess, then dialogue, then plan, and finally act on the basis of credible and accurate information.

Professor Kaseje concluded by noting that small improvements, made continuously, will have a great impact on the health system. According to Professor Kaseje, truly sustainable change occurs during the *process* of care provision: it is not a good to be delivered by the provider, but rather a result of continued collaboration, partnership and dialogue.

### **3.2 Human Rights Violations in Kenya’s Maternity Wards: the CRR and FIDA Joint Report “Failure to Deliver”**

Lucy Simiyu, KHRAN Program Officer, presented participants with an outline of a recent report released by the Center for Reproductive Rights (CRR) and the Federation of Women Lawyers in Kenya (FIDA-Kenya) on human rights abuses in Kenyan maternity wards. The report highlights the following issues:

- The lack of access to family planning services and information throughout Kenya;
- Serious abuse and neglect during delivery;
- Structural barriers to the availability of quality maternal health care;
- The many challenges facing women as they seek redress; and
- The human rights implications of these faults in the health care system.

Ms. Simiyu noted that women seeking maternity services in Kenya have suffered serious human rights violations for decades, including verbal attacks, flagrant neglect, filthy conditions and sexual assault. The CRR-FIDA report draws these conclusions from documenting over 120 women’s experiences. These negative experiences have lasting public health implications for the country, and constitute severe violations of human rights which are protected under both international and Kenyan law.

According to Ms. Simiyu, the report concludes that a shortage of funding, staff and equipment are the main plagues to the public health system, and dramatically interfere with the ability of health workers to provide adequate care during delivery. The report makes several recommendations to GoK, including the implantation and enforcement of MOH maternal care standards, the development of a comprehensive strategy to address the problem of neglect in maternity wards, the issuance of standards and guidelines for medical facilities on patients’ rights and complaint mechanisms, and the removal of financial barriers that result in the denial of or delays in receiving necessary health care services.

The report also makes recommendations to health facilities, including the protection of patients’ rights and the promotion of accountability, the establishments of fair and transparent payment policies, and the implementation of an effective identification process for newborns.

Ms. Simiyu concluded by highlighting the recommendations made to health professional associations, which include revising ethical codes to provide sanctions for all violent and discriminatory practices against women, as well as an increased emphasis on women’s rights during all trainings.

#### **3.2.1 Plenary Discussion**

During the plenary discussion, participants raised concerns about the level of health workers’ involvement in policy-making, the role of government in planning for emerging health needs in Kenya, and the promotion of health workers’ rights and women’s rights in the healthcare setting. Other concerns included:

- The insufficient flow of information from the government to the community regarding health policies and programmes;
- The progress of health worker associations (such as the KMA) in advocacy at the policy level;
- The regulation of health institutions throughout the country, and the level of professionalism at health facilities;

- Migration of health workers from rural settings to urban settings, as well as the government's contribution to migration among sectors (nurses moving from the mission sector to the public sector, etc.); and

Dr. Okeyo responded to participants' concerns regarding issues of professionalism within the health workforce and the quality of care provided in health facilities, including maternity wards. He noted that the KMA originally began as a welfare organization for doctors, but has developed into an organization with a larger role to play, including regulating its members. Dr. Okeyo emphasized that the KMA is in a position to receive complaints about particular practitioners who are unprofessional or who violate patients' rights.

Furthermore, Dr. Okeyo noted the importance of continual professional development (CPD) for health professionals, who are often not aware of current policies, programmes, rules or regulations in the health sector. Over the past two years, the KMA has initiated CPD in Kisumu, ensuring that KMA members attend a certain number of CPD courses before they can advance their level. Dr. Okeyo hopes that this type of CPD will help to minimize cases of negligence and maltreatment in health facilities. Another strategy Dr. Okeyo identified is to develop forum to audit mistakes by health workers, initiate correction processes, and institute evaluation mechanisms.

Professor Kaseje continued, and responded to participants' concerns about the cost of health care. He noted that private facilities must charge higher fees than public facilities, because they are not supported by the government. However, during 2006 faith-based organizations engaged in dialogue with GoK to develop a policy that *anyone* providing a certain level of care (whether FBO, private sector facility, or government-run facility) can be supported by public funds. Currently, when the government receives donor funds, they are only channeled to government facilities, even though there are many other facilities providing essential care. The arrival of the Clinton Foundation, and the resulting migration of nurses from FBOs to Foundation-supported positions, triggered the realization that FBOs provide critical services, and must be included in the government's health budget.

He further responded to participants concerns regarding the promotion of health workers' rights and the damaging effects of foreign migration, urban migration, as well as migration among the sectors. Professor Kaseje noted that until health workers' rights are adequately addressed, it will be very difficult for the government to address patients' rights. He recommended that the government develop different mechanisms of dialogue, ensuring that client representatives have the opportunity to sit with health facility management and exchange ideas.

However, Professor Kaseje also highlighted the critical impact of Structural Adjustment Programmes (SAPs) on the health workforce. SAPs forced a freeze on hiring in the health sector, and trained workers who were unable to be absorbed had no choice but to leave public service, and perhaps leave Kenya. He noted that, due to SAPs, the government is limited in what it can do to eliminate the health worker shortage, and that a health rights movement must focus on the larger factors that are constraining the government, moving away from placing all blame on GoK.

Dr. Suleh, KHRAN Chair, noted that the issue of health workforce development isn't solely focused on salary; rather, it's also about ensuring timely and appropriate promotions and providing proper and relevant trainings for health professionals. Currently, the health sector (including NGOs, FBOs, the private sector and GoK) cannot absorb all the trained health professionals in Kenya, and stakeholders must recognize that *all* stakeholders are responsible for budgeting, planning and providing services. The health sector as a whole must work together and streamline budgeting and planning, working together to expand access to health services throughout Kenya.

Dr. Okeyo concluded the plenary discussion by highlighting the need for health workers to become fully involved in the governance of the municipality in which they work, in particular during the planning stage. Health workers have a right to participate, but they must also demand that they be included in key

planning processes. He noted the positive effects of “city consultations,” initiated originally for HIV/AIDS, but relevant for other health services as well. He suggested advocating for the scale-up of initiatives aimed at expanding access to health care; such as the ability to purchase a card for 200 Kshs that provides services worth 1000 Kshs. He also recommended advocating for the increase of Constituency Development Funds (CDF), as well as improved allocation of the funds at the community level. This will require health workers, and health professional associations, to penetrate the processes regulating the implementation of local funds.

### **3.3 Scope of CDC Activities in Complementing Government Efforts to Achieve the MDGs and PEPFAR Targets**

Dr. Kayla Laserson, from the Center for Disease Control (CDC) and Kenya Medical Research Institute (KEMRI) presented on the scope of CDC activities in Nyanza Province, which has the highest burden of disease in Kenya. The CDC collaborates with many different institutions throughout Kenya to implement their agenda, which includes a demographic surveillance system measuring the impact of intervention on mortality, an emerging infectious disease programme examining health care utilization and symptoms of emerging diseases at the household level, malaria research, and HIV-related research and programs.

In the realm of HIV/AIDS, CDC activities are funded by the President’s Emergency Plan for AIDS Relief (PEPFAR):

- Technical and data support for Voluntary Counseling and Testing (VCT) services, working in conjunction with Liverpool VCT;
- Diagnostic Counseling and Testing (DCT) in clinical settings;
- Supportive counseling;
- Home-based VCT;
- Prevention of Mother-to-Child Transmission (PMTCT) and community PMTCT activities;
- Capacity-building;
- Provision of supplies and equipment; and
- General support and coordination.

Dr. Laserson noted the different CDC activities aimed at vulnerable populations in the province, such as adolescents, tuberculosis patients, people living positively with HIV/AIDS (PLWHA), and commercial sex workers. Currently the CDC supports HIV prevention programmes among adolescents, as well as among commercial sex workers in Kisumu.

In the area of HIV/AIDS, CDC also provides community support, trains MOH employees, and supplies basic equipment. Dr. Laserson explained that the CDC is pushing to scale up HIV care by decentralizing ARV treatment; currently the CDC is examining the possibility of having nurses prescribe ARVs to ensure increased access to HIV/AIDS treatment. The CDC also hopes to improve pediatric diagnosis, care and treatment of HIV/AIDS.

Dr. Laserson highlighted the need to link TB and HIV services: most TB services are available at the community level, but ARV treatment is only available at higher levels of care. As a result, many patients with TB simply don’t go to the higher levels of health facilities, and are not tested or treated for possible coinfection with HIV. According to Dr. Laserson, up to 80% of TB patients tested for HIV will be positive, and the CDC is currently providing facility-based support for treatment of TB/HIV coinfection. They’re also addressing this issue at the community level, providing community-based support and working to create a “TB Ambassadors” programme, which will train Community Health Workers (CHWs) in Tuberculosis.

The CDC also assists GoK with data analysis, and is working with the National AIDS and STD Control Programme (NAS COP) to build a national database. They are also undertaking capacity-building in data collection and management with MOH, which has increased significantly since 2004.

Dr. Laserson concluded by noting some of the challenges the CDC faces at the health care worker level, including the shortage of laboratory technologists, high turnover of health care workers in MOH facilities, a weak lab infrastructure, and weak information feedback mechanisms.

### **3.4 APHIA II in Nyanza Province**

Dr. Chris Oyoo from the AIDS, Population, Health Integrated Assistance Program (APHIA II) in Eastern Province presented on their recent work in the region. APHIA II supports GoK's national policies and outcomes regarding HIV/AIDS, Tuberculosis, maternal and child health (MCH) and family planning (FP). In Nyanza, APHIA II's lead partner is EngenderHealth, and with their support APHIA II implements a programme designed to create dynamic relationships between health facilities and workers and the communities they serve, integrating facility-based care and community-based care. The programme includes improving facility-based services, implementing community-based HIV prevention and behaviour change programmes, and providing care and support for people living with or affected by HIV/AIDS

Dr. Oyoo noted that EngenderHealth manages APHIA II in Nyanza, and provides technical assistance in the area of reproductive health. The programme has three key objectives in Nyanza, which include:

- Improving and expanding facility-based targeted services in HIV/AIDS, as well as tuberculosis, sexually transmitted infections (STIs), reproductive health (RH), and family planning (FP), focusing on improving services, referral systems and safety;
- Improving and expanding civil society activities in order to promote healthy behaviours, including workplace programmes to address behaviour change, promoting abstinence among youth and women's empowerment; and
- Improving and expanding care and support for people and families living with or affected by HIV/AIDS through support programmes, linking care and support services to other programmes, and training CBOs, FBOs, and other NGOs and caregivers.

In total, APHIA II is a five-year programme, and Dr. Oyoo concluded his presentation by noting that the process of handing over APHIA II to the Kenyan government will begin during the fourth year of implementation.

#### **3.4.1 Plenary Discussions**

Participants raised several concerns during the afternoon plenary discussion, including the level of collaboration between the CDC and its partners, and the need for increased participation of health workers in monitoring and evaluating donor-funded programmes. Other concerns included:

- Whether or not the Kenyan government was truly dictating its health agenda and the effect of a donor-driven agenda on the quality of care provided at health facilities;
- Whether or not the current environment in the health sector is enabling the realization of human rights, providing accessible, available, and high quality care;
- Women's access to family planning and reproductive health services;
- Promoting and protecting the rights of health workers, particularly regarding occupational safety and comprehensive health care; and
- Promoting and protecting the rights of patients during research, as well as the rights of people living with disabilities.

Dr. Laserson responded to participants' concerns regarding the level of collaboration between CDC and its partners, noting that every partner who receives PEPFAR funds is coming together to discuss different areas of interventions and responsibility. However, there are serious sustainability issues, because the money is coming into a system with low capacity and weak infrastructure. Improved training and infrastructure is critical to sustaining the impact made by the large increase in funds from PEPFAR.

In response to concerns that Kenya's health agenda is driven mainly by donors, Dr. Laserson noted that the insistence upon PEPFAR's key "targets" has encouraged some division within the health sector, because each funding recipient must report progress on meeting these targets in order to continue to receive funding. The increase in competition has led to divisions among providers in the health sector, and created challenges in terms of quality of care and treatment, particularly regarding adherence to drug regimens and the quality of long-term care.

Dr. Oyoo noted that APHIA II must continually work to balance between the need to meet targets and their responsibility to provide quality care and treatment, and he emphasized the importance of promoting the rights of the clients APHIA II works with. He noted that both PEPFAR and APHIA II support MOH priorities, and APHIA II currently supports the government's roll-out of the "community strategy." However, Dr. Oyoo also said that APHIA II must address issues of training and capacity-building at the community level.

Regarding monitoring and evaluation, Dr. Laserson noted that the CDC, and many other agencies, struggle with data dissemination, and it must work to share more information at every level in the health care system. Dr. Okeyo added that the government has developed a monitoring and evaluation framework that all health workers should be familiar with. It is a systematic method for collecting data regarding HIV/AIDS and then reporting it back to MOH in a manner that fits directly into the national strategic plan. While all organizations active in HIV/AIDS are supposed to use this framework, only 60% of organizations actually report back to the national level, which means that policy decisions are being made without enough information. However, he noted that many organizations do not have enough funds for this activity, and questioned whether or not the government is responsible for the lack of reporting.

According to Dr. Suleh, the chances of health workers becoming infected with HIV/AIDS are approximately 99.7% due to sexual behaviour, rather than unsafe practices at the workplace. He noted the need for educational behaviour change at the workplace, as well as anti-stigma and discrimination campaigns focused on the health workforce. Dr. Laserson added that it is critical that health workers know and check their status.

Dr. Laserson also noted the need for social support for people living positively with HIV/AIDS (PLWHA) as they choose to disclose their status. According to Dr. Laserson, more people are disclosing their status because of the increase in availability of care and treatment, which has led to increased dialogue on the issues of stigma and discrimination in the last year. However, she also noted that the availability of treatment has a close link with people's willingness to get tested for HIV. This gap between diagnosis of HIV and access to treatment is a major issue throughout Kenya, and Dr. Laserson noted that decentralization and allowing other cadres of health workers (such as nurses) prescribe ARVs would help to bridge this gap.

While there have been significant improvements in access to HIV/AIDS treatment, Dr. Suleh noted that there is a serious lack of access to treatment and care for multi drug-resistant tuberculosis (MDR-TB) throughout Kenya. According to Dr. Suleh, there has been money allocated to health facilities for MDR-TB isolation wards that has been returned to the government. He further highlighted the human rights implications, noting that the poorest are often the most vulnerable to MDR-TB, and that there are suspected cases in Nairobi's Mathare slums. Dr. Laserson added that next year's PEPFAR funding will support increasing laboratories' capacity to test for MDR-TB. She also noted the need for TB clinicians to share information, so that the government and development partners are aware of the true magnitude of the crisis. Currently, the CDC is working with MOH to develop a strong "TB ambassadors" program that will train community health workers in the care and treatment of TB.

Dr. Laserson also emphasized that PEPFAR provides funding for *both* male and female condoms, and would like to increase the availability of female condoms. Dr. Suleh added that the lack of access to female condoms is a serious violation of rights, and asked why the government insists on placing such

restriction on effective services. Dr. Okeyo provided a way forward on the issue, emphasizing the need to invest more in research on the female condom, as well as the need to link women to resources where they can access new health information and technology.

Regarding the rights of research subjects, Dr. Laserson emphasized that every research study requires that a person give informed consent, which includes the ability to have their specimen destroyed at any time. Dr. Okeyo noted the need for participants in research studies to receive more information so that researchers are ensured that every participant is aware of their role in the study and their rights.

#### **4.0 Priority Advocacy Issues and the Way Forward**

##### 1. Development of improved strategies for communicating with vulnerable groups

Currently, MOH communication strategies do not reach the most vulnerable groups, such as people living with disabilities, PLWHA, adolescents and women, who often remain uninformed of critical health issues, such as the availability of female condoms. While there is an HIV/AIDS communication strategy, MOH must implement a reproductive health communication strategy. Furthermore, many patients begin ARV regimens without accurate information, which severely compromises their ability to adhere to treatment and the quality of care they receive.

##### 2. Promote the greater involvement of people living with HIV/AIDS at all levels of policy-making and program implementation

Many vulnerable groups remain uninformed of MOH policies and programmes, including PLWHA, who are often placed on ARV regimens without adequate information. To remedy this situation, the government must ensure the greater involvement of people living with HIV/AIDS (GIPPA) at all levels of policy-making and programmatic interventions. This will require improving the flow of information from GoK and Ministry headquarters to health workers, facilities and consumers at the community level.

##### 3. Protect and promote the rights of health workers

The Kenyan government must protect and promote the rights of health workers. Many health workers are ill themselves, and suffer from self-stigma and discrimination. The government must implement measure to ensure occupational safety (including infection prevention), and provide a comprehensive health care plan for health workers. Furthermore, the government should develop a workplace programme for health workers addressing issues of exposure to infection, welfare and retirement. In particular, community health volunteers must be made aware of their rights.

##### 4. Improve and expand training for health workers

The government must build the capacity of health workers to respond to emerging diseases in Kenya, which includes multi drug-resistant tuberculosis (MDR-TB). Furthermore, many violations of both patients' and workers' rights are a result of inadequate information on human rights, and the government should institute human rights training for all health professionals. Health workers must be made aware of the most recent safety standards, and be aware of the opportunities to seek recourse for violations of their rights in the workplace.

##### 5. Improve access to health services for those most vulnerable to disease

The government and its partners must undertake research to learn which populations are currently the most vulnerable. Women, children, OVC, adolescents, people living with disabilities, PLWHA often do not access health services because of stigma, discrimination, or a lack of empowerment.

##### 6. Protect and promote the rights of women

A lack of empowerment among women contributes to their inability to access critical health services, such as reproductive health services, family planning options, and female-controlled

HIV-prevention methods. Furthermore, HIV prevalence among women remains higher than men, and yet their access to female-controlled HIV prevention methods remains severely constricted. In particular, women are uninformed about the utility of the female condom in prevention HIV and unplanned pregnancies. The government must increase the amount of female condoms available, and improve its communication strategy among women to promote increased usage.

7. Protect and promote the rights of patients

The shortage of health workers directly affects the quality of care provided to patients, which were documented in the joint CRR-FIDA Kenya report “Failure to Deliver.” In particular, women often suffer abuse and other violations of their rights in overcrowded and understaffed maternity wards. Furthermore, pervasive stigma and discrimination in the health setting is a violation of patients’ rights, and limits their access to quality health services. Also, during research studies participants must be fully aware of their participation and their rights.

8. Increase funding to the health sector, and ensure the efficient allocation of funds at the community level

The GoK must allocate more funds to the health sector, realizing its promise made in 2001 at Abuja of allocating 15% of GDP to the health budget. The increase in funds should be used to, among other things, hire more health workers and ensure appropriate promotions and salary increases. Furthermore, the government should ensure that increases in funding are not channeled solely to public health facilities, but also reach other facilities providing essential health services, including those in the mission sector. In order to achieve the necessary increase in funding, health workers, CSOs and policy-makers will need to address the constraints on social sector spending enforced by international financial institutions, such as the IMF and World Bank.

9. Institute effective and transparent accountability mechanisms

The government should work to implement effective accountability mechanisms that allow *both* patients and health workers to report violations of their rights and seek redress.

10. Ensure the effective integration of services provided by development partners and donor governments

The donor-driven health agenda has contributed to fracturing within the health sector, and has created challenges in terms of balancing the quality of care with the responsibility to deliver rapid results and ensure further financing. The role of each partner in providing health services, including international donors, must be clearly defined and complementary. The integration of services should also extend to traditional health approaches, which should be accommodated within the public health system, regulated, and used to expand access to health services throughout Kenya.

11. The HIV/AIDS Act must be implemented

The HIV/AIDS Act has been passed by parliament, but has yet to be implemented. The government must ensure that the Act is implemented as soon as possible to ensure the protection and promotion of the human rights and civil liberties of all people infected or affected by HIV/AIDS.

## 5.0 Conclusion

In order to address these major challenges facing the health workforce and impeding Kenya’s ability to realize the ERS goals, Vision 2030, MDGs and PEPFAR targets, health workers must collaborate with members of civil society, non-governmental organizations, the Ministry of Health and the donor community to examine possible solutions to the human resource crisis in Kenya, and its affect on access to health services and information for the most vulnerable populations throughout Kenya.

First and foremost, the government must improve its communication strategies with health consumers throughout Kenya, in particular the most vulnerable groups, such as people living with HIV/AIDS, people living with disabilities, adolescents and women. Improved communication and information dissemination must also form part of a larger strategy aimed at increasing access to health services for the most vulnerable groups, including access to female-controlled HIV prevention methods such as the female condom. Similarly, health workers must have their voices heard at headquarters level, and MOH must quickly disseminate information regarding relevant policies and programmes that directly affect the welfare of both patients and providers.

Health workers, civil society and policy-makers must work to develop policies and accountability mechanisms that protect and promote the rights of patients. In particular, health worker associations must ensure that they have instituted policies which protect and promote the rights of women as they seek health services, and that women have the knowledge and ability to seek redress for violations of their rights. Women throughout Kenya remain unaware of their rights and often delay seeking medical care because of a lack of information and empowerment, severely limiting their access to essential health services.

Health professional associations, civil society and MOH must work to firmly establish, protect and promote the rights of health workers themselves. Many health workers often suffer from the same illnesses, stigma and discrimination as their patients. They must join with the MOH to create relevant and effective support mechanisms, including a comprehensive workplace programme for all health workers, addressing occupational safety, abuse in the workplace, risks of exposure, health care, retirement plans, and other mechanisms to promote the general welfare of the health workforce in Kenya. Furthermore, the negative attitude among many health workers is one of the greatest barriers to quality service provision in Kenya, and providing increased financial and social support for the health workforce is one aspect necessary to address the situation.

Health workers and civil society must actively engage in the budget-making process in Kenya to make sure their concerns are heard and their agenda is addressed at the GoK level. The GoK must increase its resource allocation to the entire health sector, meeting its promise of 15% of the GDP. This increase in resources should be channeled to widespread support for the health workforce, including hiring more health workers, ensuring appropriate promotions, and eliminating wage ceilings. Training curriculums must be updated, including training on human rights, stigma and discrimination, and capacity-building for addressing emerging diseases in Kenya, such as MDR-TB.

Similarly, health workers must push their agenda with development partners such as the IMF and the World Bank in an effort to lift budget limitations and wage ceilings imposed by international lending institutions. At the local level, health workers must collaborate with the MOH and GoK to ensure the efficient use of government funds at the local level; this includes involvement in the allocation of CDF funds. In addition, MOH must explore new and innovative solutions to inequity in the health sector, ensuring that professionally trained health workers reach the most disadvantaged groups and that they receive the managerial, financial, and social support necessary to treat their patients effectively.

Health workers, health professional associations, CSOs and development partners must continually work to ensure service-delivery amongst them is integrated and complementary. The donor-driven agenda has contributed to fracturing among healthcare providers in Kenya, often compromising the quality of care and treatment in an effort to meet donor-stipulated targets. The government must ensure that the needs of Kenyan communities drive its health agenda, and that each development partner supports the GoK strategic plan and complements health services provided by public, private and mission health facilities.

KHRAN will work with network members, health workers, advocacy bodies such as health worker associations, health training institutions, as well as the Ministry of Health to address these issues in the coming months. The network will develop follow-up actions that ensure district health workers continually have their voices heard in the national and international policy arenas.

## Annex 1: List of Participants

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## Annex 2: Workshop Programme

<b>Time</b>	<b>Activity</b>
<b>8.30 – 9.00 am</b>	<b>Arrival, Registration</b>
9.00 – 9.15 am	<b>Welcome Remarks &amp; Introductions</b> Dr. Stephen O. Okeyo, KMA Chair Kisumu
9.15 – 9.30 am	<b>Brief Presentation about KHRAN &amp; Workshop Objectives</b> Lucy Simiyu, Program Officer KHRAN
9.30 – 10.00 am	<b>Opening Remarks &amp; Climate Setting</b> Dr. Juliana Otieno, Med Supt, New Nyanza Provincial Hospital Dr. A. J. Suleh, KHRAN Ag. Chair
<b>10.00 – 10.30 am</b>	<b>Tea Break</b>
10.30 – 11.00 am	Key Note Address: <b>Challenges and hindrances facing health professionals as Kenya strives to achieve the Millennium Development and PEPFAR goals</b> Prof. Dan Kaseje, Professor of Public Health, GLUK, Kisumu
11.00 – 11.30 am	Presentation <b>Human Rights Violations in Kenya’s Maternity Wards: the CRR and FIDA joint report “Failure to Deliver”</b> Lucy Simiyu, Program Officer KHRAN
11.30 – 12.30 pm	<b>Plenary Discussion</b> Panelists: 1. Prof. Dan Kaseje 2. Dr. Stephen O. Okeyo, KMA Chair, Kisumu Moderator: Dr. A. J. Suleh, Ag. Chair, KHRAN
<b>12.30 – 1.30 pm</b>	<b>Lunch</b>
1.30 – 2.00 pm	Presentation <b>Scope of CDC activities in complementing Government efforts to achieve the MD and PEPFAR Goals</b> Dr. Kayla Laserson, CDC
2.00 – 2.30 pm	Presentation <b>APHIA II in Nyanza</b> Dr. Chris Oyoo, APHIA II Nyanza
2.30 – 3.30 pm	<b>Plenary Discussion</b> Panelists: 1. Dr. Kayla Laserson, CDC 2. Dr. Chris Oyoo, APHIA II Nyanza Moderator: Dr. Stephen O. Okeyo, KMA Chair, Kisumu
3.30 – 4.00 pm	<b>Consolidation of Advocacy issues and Way Forward</b> Dr. Stephen O. Okeyo, KMA Chair, Kisumu
<b>4.00 – 4.30 pm</b>	<b>Refreshments &amp; Departure</b>