HEALTH RIGHTS ADVOCACY FORUM  
(HERAF)  

REPORT ON THE EFFECTS OF 2007 POST ELECTION VIOLENCE ON HEALTH WORKERS AND THE PREPAREDNESS OF THE HEALTH CARE SYSTEM IN KENYA  

Assessment Report  

2008
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List of Acronyms

AAH: Action against Hunger
AFDB: African Development Bank
AIDS: Acquired Immune Deficiency Syndrome
AMREF: African Medical Research and Education Foundation
CAR: Capability Assessment for Readiness
CEDAW: Convention on the Elimination of All forms of Discrimination against Women
CERD: Committee on the Elimination of Racial Discrimination
CRC: Committee on the Rights of the Child
CSO: Civil Society Organisation
DHMT: District Health Management Teams
DMOH: District Medical Officer of Health
DOTs: Directly Observed Therapy
DSF: District Stakeholder Forum
FBO: Faith Based Organization
GBV: Gender-Based Violence
HCW: Health Care Workers
HENNET: Health NGOs Network
HERAF: Health Rights Advocacy Forum
HIV: Human Immunodeficiency Virus
HRA: Health Rights Approach
ICESCR: International Covenant of Economic Social and Cultural Rights
ICRC: International Committee of the Red Cross
IDP: Internally Displaced Person
IMCI: Integrated Management of Childhood Illnesses
IMR: Infant Mortality Rates
KCOA: Kenya Clinical Officers Association
KEMSA: Kenya Medical Supplies Agency
KEPH: Kenya Essential Package for Health
KHRC: Kenya Human Rights Commission
KMA: Kenya Medical Association
MDG: Millennium Development Goals
MEDS: Mission for Essential Drugs and Supplies
MoH: Ministry of Health
NGO: Non-Governmental Organization
NHSSP: National Health Sector Strategic Plan
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<td>NNAK</td>
<td>National Nursing Association of Kenya</td>
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<td>OECD</td>
<td>Organization for European Cooperation and Development</td>
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<td>PEV</td>
<td>Post-Election Violence</td>
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<td>PHMT</td>
<td>Provincial Health Management Team</td>
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<td>PHR</td>
<td>Physicians for Human Rights</td>
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<td>PLWHA</td>
<td>People Living With HIV &amp; AIDS</td>
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<td>Provincial Medical Officer</td>
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<td>RRI</td>
<td>Rapid Results Initiative</td>
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Executive Summary

This report is an assessment of the effects of the 2007 post-election violence on the health care system in Kenya. The purpose of the assessment was to examine and document the effects of the violence on health care workers, and determine the level of preparedness of the health system to provide services in emergency conflict situations.

The sampled locations for the assessment were Nairobi, Kisumu and Eldoret. Each of these regions had a fair share of the violence. The report is based on data from qualitative, in-depth interviews conducted with health care providers, key policy makers at the MoH headquarters and representatives of civil society involved in the provision of care during this period.

The report shows that health workers were affected in a number of ways, including displacement from their workplaces, inability to access health facilities, fear for their security and loss of trust, exemplified by the development of frosty relations with patients and some fellow colleagues. The displaced workers belonged mainly to the non dominant ethnic groups in the study areas. Although some of these effects may have been directly caused by the PEV, it is clear that health workers lacked appropriate workplace support mechanisms that could have helped them to navigate the various challenges they faced during that period. For instance, there was no psychosocial support to address the trauma and stress experienced by health workers during the conflict period, which exacerbated the impact of the violence on the health workforce.

At the health system level, the violence had three main effects. First, PEV led to a breakdown in the continuum of care, as many people were separated from health care facilities, and remained so for the duration of the violence. This breakdown negatively affected access to health care facilities among people who were consigned to displacement camps, as well as the host communities who feared to venture out of their homes due to insecurity. In other cases, some health care facilities were unable to meet the health needs of both the host community and the “newcomers” from other areas.

Second, there was a serious disruption of logistics and supply chain coordination. Although most of the health facilities were able to function for the first few weeks without replenishing the stocks, pressure on health facilities to provide services increased in the face of decreasing stocks of medical supplies, which was due in part to the closure of both road and rail services. However, it is important to note that the central medical stores at KEMSA had enough drugs; the major challenge was how to deliver them to the affected areas.

Third, most public health facilities did not have the capacity to follow up with patients who were unable to access health care facilities. The combination of these three effects was to incapacitate
the ability of the health care system to provide equitable, accessible and quality health care services as outlined under the KEPH strategy. As a result, this puts into question the ability of the health care system to deliver expected services even under normal circumstances.

The assessment concludes that the health care system was ill equipped to adequately deliver the necessary health care services during the conflict period. The report recommends to the government to develop a workplace support mechanisms, re-train health workers on the rights based approach to health and building their capacity to handle issues related to psychosocial including Sexual and Gender Based Violence (SGBV) health needs.

On the health system the report urges the government to implement and prioritize the recruitment and improve on the distribution of all cadres of health workers. There is also the need to institutionalize a psychosocial health unit within the MoH. Also, a public awareness campaign should be conducted on the need to respect and protect health workers. It is further recommended that HERAF spear head the development of a Capability Assessment for Readiness (CAR) tool that can form the basis for self evaluation among key actors in the healthcare system. The results of this self assessment should form the basis for developing future emergency preparedness plans.
Section One: Introduction and Background

1.1 Background

Health Rights Advocacy Forum (HERAF) is a non governmental organization 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, with support from Physicians for Human Rights (PHR) USA 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.

HERAF envisages a Kenya where health is upheld and enjoyed as a fundamental human right. The mission is to be a leading human rights organization that promotes and empowers Kenyans to realize the right to health for all.

The programmes and activities of HERAF are guided by the rights based approach principals. The rights based approach is critical in addressing growing country’s health inequalities. The approach include holding states and other parties accountable, developing policies and programs consistent with human rights, and facilitating redress for victims of violation of the right to health. It also offers a framework for pro-active development of policies and programs consistent with human rights.

Health workers in Kenya are frequently unable to provide adequate health care services due to systemic factors outside their control. This study was therefore mooted to access whether or not the delivery of health services during the PEV was in line with the human rights standards that the KEPH is designed to deliver.

1.2 Terms of Reference and Scope of Work

The terms of reference (TOR) for this work were as follows:
1. To examine and document the effects of post-election violence on health care workers in Kenya.
2. To determine the level of preparedness of the Kenyan health care system to provide health services in emergency conflict situations.
3. To identify advocacy issues relating to Kenya's health care system and post-election violence in Kenya.

This report explores the effect of post-election violence on both health care workers and the health system. The three regions Nairobi, Kisumu and Eldoret were chosen for their location within or their proximity to the PEV hotspots. It is hoped that the report is a fair representation
of what might have happened in other places in the country that experienced post-election violence, even though these effects differed in extent and magnitude.

1.3 Description of Methods Used
This assessment is based on data that rely on the experiences of key stakeholders involved in the provision of health care services during the post-election period. Qualitative research techniques were used to gather information from health care workers, health officers and policymakers. Supplementary data was gathered from reports and documents on the effects of post-election violence in Kenya. This report is based on twenty-one individual, in-depth interviews that were conducted in Nairobi, Kisumu and Eldoret.
Section 2: Literature Review

Overview
In most cases, emergency conflict situations are characterized by violations of basic human rights, which are preceded by a breakdown in social order\(^1\). In addition, such situations lead to major population displacement, insecurity, food and water shortages and lack of access to shelter and sanitation\(^2\). Other characteristic results of such situations include sexual assault and discrimination against women and other vulnerable groups\(^3,4,5,6\).

These conditions severely undermine people’s ability to gain access to both preventive and curative health care services. In addition, health care workers suffer various forms of injustices and human rights violations, including threats, intimidation, harassment and even interference with treatment decisions by the combatants, all of which affect their ability to deliver health services. Generally, emergency conflicts lead to a catastrophic public health crisis in which the victims are civilians\(^7,8\). Most deaths during the emergency conflict periods are preventable, caused by infectious diseases, malnutrition and violent trauma\(^9\). The PEV in Kenya exhibited similar characteristics and thus may be referred to as a public health crisis\(^1\).

In normal, non-emergency situations in Kenya, health service delivery is characterized by a variety of health facilities offering different levels of care, and it is often difficult to ensure synergy amongst all the actors within the health system. The onset of the emergency situation further complicates the delivery system, since the skilled staff and specialized supplies needed to provide a minimum level of services at the various facilities are often unavailable.

This assessment used three interrelated frameworks when examining the two objectives. These frameworks include the rights based approach, the right to health and the Kenya Essential Package for Health (KEPH) strategy that guides health service provision in Kenya.

2.1 Rights Based Approach to Health Programming

The rights based approach (RBA) to health uses human rights and their accompanying standards to guide the design and implementation of health care services and strategies. The RBA to health programming is mainly used to foster respect, protection and the fulfillment of core human rights obligations\(^\text{10}\). The approach acknowledges that people have a right to health for instance, and are entitled to a valid claim from the government (duty bearer), which is expected to implement it. In 2000, the UN established four (4) human rights standards to define the right to health, through the creation of General Comment No. 14 of the International Covenant of Economic Social and Cultural Rights (ICESCR)\(^\text{11}\). These standards have since been used as indicators when determining progress towards fulfilling the right to health.

First, preventive and curative health services must be available. This does not only require provision of drugs and other medical supplies, but also availability of care givers, public health facilities and other goods and services to complete the continuum of care. Second, preventive and curative health services must be accessible. These services must be devoid of all barriers that impede access, including geographical, social and economic barriers. In addition, the services must be provided to all on a non-discriminatory basis.

Third, health services must be acceptable to the consumers in terms of how they are provided and their compliance with the social values of the user. In this case, cultural appropriateness includes sensitivity to gender and life cycle requirements, as well as respect for privacy. Fourth, services provided at various points of care must be of good quality. This standard requires that, at a minimum, properly trained personnel should provide the services and include provision of approved drugs and hospital equipment, adequate nutrition, water and sanitation, among other aspects.

A rights based approach therefore integrates human rights norms and principles—such as human dignity, attention to the needs of vulnerable groups and equity of access—in the design,


\(^\text{11}\) Ibid.
implementation and evaluation of health related policies and programmes. Others include the principles of equality and freedom from all forms of discrimination.

The Kenyan government is therefore required under international law to respect, protect and fulfill the health rights of its citizens at all times including during conflict situations. Within the broad remit of human rights, respecting health rights demands that states refrain from carrying out, sponsoring or tolerating any practice, policy or legal measure that may violate the integrity of individuals, or impinge on their freedom and jeopardize the enjoyment of these rights. Failure to employ adequate health care workers, provide adequate health facilities or the introduction of taxes that impede access to health care may be interpreted to constitute a failure to respect such rights.

On the other hand, protection of health rights requires the state to prevent other actors from interfering with the enjoyment of those rights. Fulfilling the right to health requires the government to take active measure to promote its realization, and this includes advocacy, public expenditure, and government regulation of the economy, the provision of basic services and related infrastructure, and redistributive measures. Therefore, the duty of fulfillment includes those active measures that are required for guaranteeing opportunities to access one’s entitlements.

Based on this understanding, states are under obligation not to engage in practices that disproportionately exclude certain individuals or groups from having access to health services. In recent years, however, health trends in Kenya have worsened. For example, life expectancy at birth decreased from 57 years in 1999 to 47 years in 2003, while the infant mortality rate (IMR) increased from 74/100,000 live births in 1998 to 78/100,000 in 2003. The maternal mortality rate reduced from 590 to 414 per 100,000 live births, while deliveries by skilled attendant dropped from 42.1% to 40.1% in 1998 and 2003 respectively. These trends highlight two issues. First, deficiencies in past approaches have brought the country to the current state. Second, there is a need to re-orient the health system to face resurgent disease, decreasing access to health care and unanticipated emergency situations.

Until fairly recently, the MoH has used the ‘basic needs approach’ (BNA) to address the health needs of communities in Kenya. The BNA focuses on curative services, and has been largely ineffective as a guiding framework for the organization and delivery of health services in Kenya. This may be attributed to the fact that a needs based approach does not have a person or


To address this inefficiency, the Kenya Essential Package for Health (KEPH) strategy was adopted by the MoH in order to align health care services with the broader aspirations of a rights based approach to health.

Despite this shift in thinking and the adoption of some elements of the RBA within the current MoH National Health Sector Strategic Plan (NHSSP II), the right to health is not explicitly enshrined in the Kenyan constitution. However, Kenya is a signatory to several conventions such as the Convention on the Right of the Child (CRC), the Convention on the Elimination of all forms of Discrimination against Women (CEDAW) and international and regional instruments and treaties that provide the foundation for human rights. In addition, Kenya subscribes to various pieces of legislation that, to a greater or lesser extent, protect health directly or otherwise as a result of the recognition of a greater right to equality or freedom from discrimination.

The use of a human rights framework in this study will allow an analysis of the connection between and among rights, as well as identifying specific rights violations and the accompanying responsibility of duty-bearers to address these violations. In particular, the rights based approach in this study allows an assessment of the availability, accessibility, acceptability and quality of the health care services provided during the PEV period, as well as an examination of the responsibilities of the government vis-a-vis addressing the system wide weaknesses that support or hinder the provision of health care services.

2.2 Organization of Health Service Delivery in Kenya

Under the direction of the Ministry of Health (MoH), the health system in Kenya serves four main functions: stewardship (oversight, vision and direction of health policy), service provision (Including formal, informal, public and private service providers), financing (collecting, pooling and purchasing) and resource generation (human resources, physical capital, drugs and medical supplies), with an ultimate goal of protecting and improving population health.

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The health care system in Kenya can be divided into three official sub-sectors: public, voluntary and private. The public sector comprises the Ministry of Health (MoH) and Ministry of Local Government (MOLG). The voluntary sub-sector consists of the mission health services and the health activities of Non-Governmental Organizations (NGOs). The private sector includes the medical services provided directly by private health facilities and health professionals in private practice, also referred to as the private for-profit sectors. A fourth, unofficial sub-sector exists, comprising of institutions and providers over which the MoH has no control. These include practitioners of traditional medicine, including herbalists, bonesetter spiritual healers and others.

In terms of health facilities in Kenya, 51% were MoH facilities while the remaining 49% were FBO/NGO and private for-profit sector facilities. The public sector is the major provider of health services, providing 58% of all health facilities, 52% of all beds and employing 70% of all health personnel. The NGO sector is dominant in health clinics, maternity and nursing homes (94%) as well as medical centers (86%). There is however little specific data on private for-profit facilities in the country. The health services provided within this health care system are delivered through a tiered system with six levels of care, as shown in figure 1 below.

![Figure 1: Levels of Care in KEPH](image)


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Provision of health care in Kenya is, however, undermined by several factors. One of the major constraints is insufficient human resources for health. It is estimated that the doctor to patient ratio is 15 per 100,000, while that of nurses is 133 per 100,000 in the public sector\textsuperscript{20}. This is attributed to problems associated with recruiting unemployed yet trained health workers into the health system, and retaining staff that is already employed. In addition, other factors undermining health care delivery include poor access to health facilities. For example, only 30\% of the rural population has access to health facilities located within 4 km, while such access is available to 70\% of urban dwellers. As a result, the proportion of births attended to by skilled health workers for instance reduced from 44\% in 1993 to 40.1\% in 2003\textsuperscript{21}. Additionally, life expectancy at birth reduced from a high of 60 years in 1989 to 47 years in 2003. In particular, the arid and semi arid areas of Kenya are the most underserved due to an extremely limited number of health facilities. The quality of health services in these areas is reportedly low due to inadequate supplies and equipment, as well as lack of personnel.

The government is currently implementing several strategies to address these challenges and improve health service delivery. These include developing better staff tracking systems in order to improve distribution and deployment of health care workers, post-matching to ensure health workers are recruited and posted where they are comfortable and needed, and performance based career training, promotion and mobility.

2.3 Post Election Violence and the Provision of Health Care Services

2.3.1 Overview

On December 30, 2007 protests related to the outcome of the General Election began in Nyanza, Rift Valley, Western and parts of Nairobi and Coast provinces. By December 31, the protests had turned violent in most of these regions. Many people within these regions were displaced, and those affected began to reside in shelters set up in various parts of the country, such as Central, Nairobi, Rift Valley, Western and Coast Provinces.

In the process of escaping the violence, many families lost their crops, animals, homes, businesses, contacts and family members from death or injury as they fled for safety. They also lost vital documents, such as the title deeds needed to claim ownership of land, identification cards, and birth and education certificates. The few that managed to salvage property could only


carry a handful, while what they left behind was set on fire by arsonists. Crude weapons, including machetes, pangas, arrows, spears, stones and guns were used against perceived enemies.

The injured were rushed to various health facilities for medical attention, and as the number of victims increased, the situation rapidly developed into a health crisis. Medical supplies were running low, health personnel were inadequate their movement was limited due to widespread insecurity. Crisis centers were set up at Nyanza Provincial General Hospital in Kisumu, Moi Teaching and Referral Hospital in Eldoret and Kenyatta National Hospital in Nairobi to provide medical assistance. In order to ensure effective coordination, a crisis management team was set up at the Ministry of Health Headquarters. Among other duties, the team oversaw the dispatch of medical supplies such as oxygen and blood, collection of data from the health facilities and the mobilization of more health workers in order to provide the necessary services at health facilities.

In general, the post-election crisis in Kenya created three groups who were most at risk of reduced access to health care or required additional health care services. One, Internally Displaced Persons (IDPS. These are people who had moved from their homes to ‘camps’. Two, affected communities: people living in areas where there was violence, and whose security could not be assured. Three, host communities: people living in areas where IDP camps were located.

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Fig. 2: Initial PEV Hot Spots


Though these groups faced different health challenges, all required public health interventions to prevent disease, provide clinical services for those who were sick, and provide appropriate social amenities such as shelter, clothing, food and water to prevent the outbreak of communicable
diseases. In total, the violence resulted in about 56 IDP camps of about 304,000 people spread across the 6 provinces of Central, Coast, Nairobi, Nyanza, Rift Valley and Western.

2.3.2 Health Challenges Posed by Post-Election Violence
Post Election Violence brought with it several major challenges to Kenya’s health system, described in detail below.

The Post-Election Violence Challenge to HIV and AIDS Programmes in Kenya
This study examined the effect of PEV on HIV&AIDS treatment programmes because it is one of the highest financially supported health care services in Kenya. Despite the attention paid to HIV&AIDS, the PEV posed daunting challenges to prevention, treatment, care and support services in the country. There were disruptions at the level of the individual, family, community and medical institution.

Affected people were accustomed to accessing services within their locality that played a dual role of encouraging adherence to treatment, as well as providing psycho-social and economic support. As a result of being displaced, many patients were unable to access their regular clinics for drug refills and continued HIV care services. Some health facilities received large influx of displaced patients for ART refill while others experienced low turn out of their regular clients. There were fears that many clients may have interrupted their ARV drug intake. For example, out of the 24,000 patients on ARVs through the Academic Model for the Prevention and Treatment of HIV/AIDS (AMPATH) in Nyanza and Rift Valley provinces, only 5% from its 19 centers across the two provinces reported for a refill of drugs 3 weeks after the outbreak of the violence. The rest of the patients could not be immediately traced. In Nyanza, the situation was further complicated by hostilities meted against the health officials who attempted to visit patients in the camps.

The MoH acknowledged the problem and advertised in the print media that those who are displaced and on ARVs should go to the nearest clinic for refills. Unfortunately, this was further complicated by the fact that most of them had lost their records during the skirmishes, which made it difficult to receive assistance in other clinics. Nonetheless, the MoH, together with its partners, devised strategies that ensured all needy patients were able to access medical care within and without the camp. Provincial teams, in cooperation with their regional partners, reached the clients through print media, announcements in camps and active searches by health care providers at the camps. The teams established temporary and mobile clinics to provide
health services and established strong linkage systems with local hospitals that handled all special cases, including ART, mainly in Nairobi, Rift Valley and some areas of Nyanza province.

**Sexual and Gender Based Violence (SGBV)**

Increased cases of sexual and gender based violence, especially rape and forced circumcision, related to the post-election violence were reported. While women and girls were the worst affected, there were cases of men who reported having been sodomised or circumcised. For example, between 24th Dec 2007 and Feb 29th 2008, 322 cases of SGBV were reported at the Nairobi Women’s Hospital, while 32 were reported at Moi Teaching and Referral Hospital. This was exacerbated by the fact that there was little recourse for help as services to address issues related to SGBV were not available.

Assessments showed that many SGBV cases remain unreported for fear of reprisals, with few victims receiving any assistance to deal with their trauma. As such, the efforts to respond to SGBV were insufficient to deal with the issues experienced. Though survivors of rape were encouraged to visit health facilities for counseling services and administration of Post-Exposure Prophylaxis (PEP), lack of awareness about the 72 hour window during which the treatment is effective, insecurity or lack of resources to travel to the facilities where these services were being offered could have resulted in an increase in number of infections.

Psychosocial issues arising from the effects of the PEV have been described as the ‘silent emergency’. Many people were unable to leave their homes to go to IDP camps or elsewhere as this meant that they had to pass through hostile regions. In terms of healing and recovery, this has more serious long-term implications for post-conflict health and social development than the more widely publicized plight of internally displaced people in the country.

**Human Resources for Health**

Within a short period after the onset of the violence, insecurity became a serious problem affecting service provision in hospitals. A significant number of health workers had been displaced, with some unable to report to their stations of duty due to insecurity or were themselves victims as they were from communities that were being targeted. For example, as of the 22nd January, 2008, 7 facilities were closed and 19 health care workers were displaced as a result of this violence in the North Rift Valley region. Also, the National Nurses Association of

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24 Ibid.

Kenya (NNAK) reported the displacement of more than 1,000 nurses. About a hundred of these had their houses torched and 10 could have been injured in course of their duties.\textsuperscript{iv}

In addition, there was a serious shortage for health workers in the IDP camps across the country. At least a minimum of 4 health workers (2 nurses, 1 public health officer and 1 nutritionist) were required per camp. Under its “Strategy No. 6,” the MoH planned to recruit an additional 200 short-term health care workers to ameliorate the staff shortage throughout the country, with support from development partners\textsuperscript{26}. In deed, UNICEF provided resources that enabled the MoH to recruit 200 additional staff on a short-term basis. However, it was difficult to post them in some of these sites due to an inability to provide or assure adequate security.

In its reaction to the violence, the Kenya Medical Association (KMA) expressed the frustrations that faced doctors and health care workers in their quest to provide medical services to Kenyans during the emergency. There was a general feeling that health care workers were not protected adequately, which made them feel insecure at their places of work. The state security apparatus were further accused of hampering the provision of health care services. In particular, the police were accused of invading healthcare facilities\textsuperscript{v}. If not addressed, the combination of lack of security and frustrations at the workplace would put the public health care delivery system at risk of collapse.

**Emergency Trauma Management**

According to assessments conducted in Nairobi and other parts of the country, emergency trauma management was identified as one of the most pressing needs for survivors of post-election violence, including affected health workers. Reports of beatings, hackings and arson were widespread. In one incident, 19 women and children were reportedly burned alive in their house. In another incident, 30 people, some of whom were children, died when the church they were hiding in was put on fire by a mob in Eldoret.

Trauma victims requiring medical attention overwhelmed the medical facilities. When particularly violent clashes broke out, trucks full of injured or dead people arrived at hospitals, which in turn became so over-crowded that patients were being treated in the corridors. A system of triage was implemented at many institutions, thus helping to treat the most severe patients first. Patients were being rushed in with broken bones, stab injuries, blunt trauma, arrow stabs and burns. Doctors reported certain cases where patients had sustained machete wounds that resulted in near-amputations. Flying surgical teams were put on high alert, responding to

violence in inaccessible regions. In the worst hit areas, temporary first-aid posts were set-up to quickly stabilize victims while waiting for transport to hospitals. Any person who was in critical condition and needed specialist care was air-lifted to the closest hospital. Many of the victims were and still are mentally traumatized from witnessing the violence or having lost loved ones.

Supplies and medical staff were thus needed to treat victims of shootings, burnings, beatings, slashing and trampling. Indeed, the need for psychosocial support and reproductive health kits with PEP were essential but were not available on the ground. In deed KMA observed that the psychological trauma experienced during the post-election skirmishes would live with health workers for a long time before the effects are completely wiped out.

2.3.3 Other Challenges Posed By PEV

Coordination of PEV Responses
One of the major challenges that developed shortly after violence broke out was coordination of the many different actors (state and non-state) who responded to the crises. Their response was largely uncoordinated, which made delivery of services difficult. Initial meetings were held to establish roles and norms of conduct in addressing issues arising from PEV. This involved identifying and asking stakeholders to organize how to respond to the emergency. After initial meetings, it was agreed that the MoH would use its existing coordinating mechanism within the health sector, such as the District Health Management Teams (DHMT) and District Health Stakeholder Forums (DHSF), while the Provincial Health Management Team (PHMT) coordinated responses at the provincial level.

In general however, coordination of responses to the PEV was poor, and greatly affected by changes in the nature of the population served. The quantities and numbers of those affected assimilated in the host community and elsewhere are still not known. Furthermore, the changed socio-cultural and population dynamics in most provinces meant that developing adequate community services to respond to those affected in the community was difficult at best.

Additionally, in some of the affected areas, the population was highly scattered. As a result, the responses for each affected area had to differ. It is instructive to note that although the MoH maintained that the health care system was well prepared to deal with the provision of health services under emergency situations, all the above planning had to be done post facto. Most of the strategies that were planned after the emergency such as needs assessment, establishment of staff requirements, waiver of fees and support for referral systems should form the basics of any emergency preparedness plan.
Managing Displaced Persons and Their Needs
Although it still remains difficult to establish the exact number of the people who were displaced, most relief agencies reported approximately 300,000 people were displaced as a result of post-election violence. In February, displaced families continued to move into the IDP camps in response to a fluctuating security environment or in search of a host community with sufficient food and employment resources. The inability to establish the exact number of IDPs was compounded by the presence of more than 290 spontaneous settlement sites across central and western Kenya, which made it difficult to identify and track ongoing population movements. Further, many relief organizations did not document displaced individuals who never passed through transit sites.

In many health facilities, insecurity was a major challenge to service provision during the post-election violence. A significant number of health workers had been displaced, with some unable to report to their posts of duty. Most facilities where IDPs had moved became overstretched, as their resources were not at a level to sustain the sudden influx of patients. Besides the aforementioned issue of security of the person as well as the facility, there was no security for personnel driving trucks delivering medical supplies, food, clothing and shelter to people and health facilities in IDP camps. Vehicles moving into the affected regions, especially those traversing the Rift Valley, had to be part of convoys with heavy security. Most of the places were rendered impassable by cutting of roads and barricading.

Hospitals were able to respond to the crisis adequately for the first two weeks, but as the fighting continued, they began to run out of supplies, especially surgical equipment and drugs. This was attributed to the numbers of patients coming to these facilities. A common problem was inadequate medical supplies due to the fact that the drugs and commodities replenished by KEMSA were provided based on routine needs but were used in the emergency. Since many of the hospitals were near IDP camps that had very many people, stock outs of medical supplies, especially drugs, became a common problem. Additionally, lack of fuel and insecurity that affected distribution of drugs and commodities resulted in many hospitals not having drugs or medical supplies to treat patients even when there was staff to do the work. This situation increased pressure on non-state actors - especially faith based health facilities - because they do not have budgets for emergency response.

It is apparent from the above review that the PEV in Kenya was no exception to other emergency conflict situations with regard to human rights violations. Forced evictions and displacements, violence and assault, especially along gender lines, shortages in basic supplies and threats and intimidation of health care workers were a common feature of this violence.
Section 3: Results and Discussion

3.1 Effects of post election violence on health workers

3.1.1 Displacement
Insecurity of various kinds led to displacement of health workers from their workstations. Health workers who lived and worked among communities that were different from their own were forced to flee to safer places, such as camping in police stations, joining fellow members of their ethnic groups in displacement camps or relocating to relatively safe places like Nairobi. While it was not possible to establish facility level statistics on the actual number of people affected, unconfirmed reports indicate that overall, close to 1200 health workers were displaced from their places of work.

Box 1: Displacement of health workers

... Quite a number were displaced by the violence by virtue of belonging to different communities other than the local community. Here you either were a supporter of ODM or you were evicted but the worst bit was that professing for the party alone was not enough. You also had to belong to the correct ethnic group to be accepted as one of them. (Resp 2, Kisumu)

...So personnel from the so-called enemy tribes simply chose not to work whereas others for their own safety chose to relocate to Nairobi until things cooled (Resp 2 in Eldoret)

Cases of insecurity were not confined to residential places where health workers lived, but also spread to the work place. Health facilities in several places were targeted for attach by violent gangs. There were reports in Nairobi, Eldoret and Migori where health facilities were invaded and workers held hostage. In the case of Eldoret, security personnel threw tear-gas canisters into the hospital in an attempt to flush out the violent gangs. It was also reported that violent gangs invaded a hospital in Nairobi in a bid to rescue a colleague who had been taken to the hospital after sustaining injuries in the violence. Most importantly, this invasion was staged in the full presence of the security personnel who were deployed to guard the facility. The message to the health workers was clear; that even with the security personnel available, they were not secure.
Although security personnel were deployed around some health facilities, most respondents complained that little effort had initially been given to making the working environment of the caregivers secure under a conflict situation. Some respondents recommended that health facilities should have reliable enclosures or perimeter fences that make them easy to secure when need arise. The magnitude of insecurity to the health workers is, however, quite revealing considering that no respondent talked of any special arrangement to provide security for health workers outside their workplace. The failure to make security-related arrangements to help health workers gain access to the health facilities was not only a case of neglect to them, but a general failure by the health care system and the government in particular, in ensuring that healthcare services were accessible to patients during the conflict period.

**Box 2: Lack of security arrangement for health workers**

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<thead>
<tr>
<th>Quote</th>
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<tbody>
<tr>
<td>...The security personnel tried to provide security to the health worker but this was only within the facility. The moment these health workers left the facility they were on their own.</td>
<td>Resp 2, Eldoret</td>
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<tr>
<td>...there was no special arrangement for us. It was just the normal patrols by armed askaris. We were just lucky that this facility was not stormed. I think even the mobs has at least some respect for health facilities</td>
<td>Resp 3, Nairobi</td>
</tr>
<tr>
<td>...security was only provided around the clinic but as for the workers once they left the facility then they were on their own. And that is why two of them ended up being beaten up by the mob.</td>
<td>Resp 6, Nairobi</td>
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Of course there were not enough security personnel to provide individual escort to personnel i.e. the health workers. And this is where the danger lied. As they say, there is security in numbers but once they (workers) left the health facility they were entirely on their own.  
(Resp 2, Eldoret)

The wide spread insecurity posed great danger to the lives and property of health workers. It should be remembered that for health workers to fulfill the responsibility of saving lives, they too must be assured of a basic minimum of security. The Geneva Convention, international law and the ethics of medical practice under conflict situations stresses the need to uphold medical neutrality, which entails the protection of health workers, patients and health facilities by all combatants during conflict situations.

The failure by the feuding groups to respect this neutrality led to both an abuse of health care workers’ rights and the right of affected populations to access health care. Health workers were
denied access to their places of work and, ultimately, the opportunity to offer much needed health services during that period. Others were threatened with retribution for acting ethically by treating victims of violence, especially those considered by combatants to belong to the “enemy” ethnic groups. As the above evidence suggests, the government failed in its responsibility of providing a safe working environment for the provision of health care services. This failure did not only threaten the availability of health care services, but also their accessibility and quality.

3.1.2 Transport crises and lack of mobility

Access to health care services was further compromised by the inability of health workers to report to their duty stations. The breakdown of public transport, especially in areas prone to violence, kept most health workers and patients away from health facilities. Interviews with health care managers showed that even those workers who were not displaced failed to report to their places of work as required. This was further complicated by the fact that violence erupted at a time when most people, including health workers, had traveled upcountry to either participate in elections or celebrate Christmas and New Year’s holidays.

It is important to note that those interviewed did not mention any plans to provide accommodation for the workers during such periods of uncertainty. In addition, there were no special arrangements that were reported for picking and dropping health workers during this period. This was only reported in Nairobi, where one health care manager reported that ambulances were used to pick and drop members of staff under the guise of ferrying the injured to hospital. Although this displacement was different in scale, it was a common feature across all the sites visited for this assessment. Even in relatively “safer” places like Nairobi, it was reported since the fracas broke out; health facilities did not operate with all staff present even for a single day, despite the high number of casualties that needed to be treated.

Lack of staff accommodation in most of the health facilities in areas hit by violence meant that health workers had to commute on a daily basis, notwithstanding the prevailing insecurity and unreliable transport system. This problem was felt more within health facilities that offer inpatient care. Staff rotation and shifts were severely interrupted, and it was not unusual for some health care workers to be on duty for extended hours without replacement. While providing staff accommodation may not be practically possible, several health care managers felt that even a minimal amount of secured accommodation to house critical or skeleton staff during an emergency period would have spared health workers the risk of attempting to access workplaces during those periods. The fact that most of the health facilities operated on skeleton staff at such a period should be a course for concern. The staff shortages that were experienced as a result of insecurity and transport crises must have affected the availability and access to health care services among the victims of violence and the general population.
3.1.3 Mistrust among Peers and Rejection by Patients

The few health workers who overcome other challenges and reported back to work faced yet another set of challenges, including suspicion, mistrust and even rejection by their patients. Ethnic animosity found its place in the workplace, and even colleagues who had worked amicably before reportedly became uncomfortable with colleagues from other ethnic groups.

Interestingly, cases of mistrust were not only reported in rural towns/areas, but also in cosmopolitan places like Nairobi, which would otherwise not belong to any particular ethnic group. One respondent working in Eldoret narrated how she felt threatened and insecure after she managed to report back to work after violence had subsided. Some health workers were also molested, by being forced to wave white pieces of cloth depicting peace or being asked to confess or demonstrate allegiance to certain political parties.

Box 3: Mistrust and rejection of health workers

“I even felt threatened when I came back to work and heard the talks that were going around that workers from certain ethnic groups should leave this region if they don’t belong here, so I really felt threatened about that and felt, am I at the right place? Is this the place I should work?” (Resp 3, Eldoret)

Mistrust and suspicion from colleagues was reported to have eroded collegiality among health workers and to have greatly reduced productivity, social support and delivery of services. Most health care managers reported that they noticed a sense of tension and resentment among workers. They reported that workers were generally apprehensive and suspicious of each other, and teamwork was slowly disappearing. For instance, a respondent from one of the health facilities in Kisumu reported that sharp differences and a sense of suspicion were almost bringing the institution to its knees because members of staff were no longer working as a team, and each was pulling in a separate direction.

This experience was made worse by encounters with patients, who preferred to be treated only by health care workers from their ethnic groups. While this rejection may sound trivial, it has the potential to undermine the foundation of the caring profession, which is built on a fiduciary relationship that demands that patients have complete trust in their care-giver, so that they (patients) can entrust their health to them. Conversely, in such a relationship, the care giver is not just another service provider, but is under obligation to use his/her best knowledge and judgment.
for the good of the patient. The effect of such mistrust on the patient-provider relationship within a medical encounter is vividly captured by sentiments below, expressed by health workers in Eldoret.

**Box 4: Rejection and clinical encounter**

<table>
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<th>...I recall a man whose family asked me to treat him and for a while I actually felt uncomfortable. I felt like telling them to look for another doctor because I feared they would reject me, or the other way around, in case of any accident, it would be taken to be intentional, as an extension of this particular fight... (Resp 1, Eldoret)</th>
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<tr>
<td>...One very painful thing I saw in the wards was that when you walk around delivering the drugs, some patients would not take and we had to look for the appropriate clinician from a respective ethnic group to deliver the medication... (Resp 2, Eldoret)</td>
</tr>
<tr>
<td>...There were initial fears from members of the public from certain communities that if they came to the facility they will be given a lethal injection by members of staff not from their own community. (Resp 3, Nairobi)</td>
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The ethnic dimension that engulfed the provision of health care services during the post-election violence period was so serious that even people who had initially volunteered to work with humanitarian organizations to assist in treating and distributing relief supplies to victims of the violence were rejected if they belonged to a different community, other than the one where the humanitarian support was being provided. One respondent from an organization that was involved in the delivery of humanitarian support narrated how this new development made it difficult for the organization to use volunteer health workers to intervene due to such enmity.

Voluntary services during emergency situations are a common practice for helping service providers to cope with high demand as they change from normal capacity to surge situation. The rise of ethnicity as a condition for acceptance into the community might have compromised the ability of these organisations to intervene during this period.

The development of fault lines within the patient-provider relationship on one hand, and the breakdown of collegiality among health workers on the other, should be of major concern. The reported loss of trust or confidence by patients to be treated by health workers from a different ethnic group indicates a serious issue that may need to be addressed by the health care system before it becomes entrenched in the service delivery. Similar suspicions were also reported
among health workers themselves, who exhibited some forms of hostility against their colleagues. As noted elsewhere in this report, undermining the trust that cements the relationship between patients and their physicians, as well as the collegiality of the caring profession, is one of the greatest challenges brought about by PEV on the health care system.

Some key pertinent lessons can be derived from this particular development. First, the quality of care was compromised during this period since accessibility of health care services was negatively affected by mistrust between patients and providers, exemplified by the fact that many patients did not want to be treated by health workers from a different ethnic group. Second, the government’s obligation to protect, promote and fulfill the right to health requires that any obstacles that may impede the enjoyment of the right to health be eliminated. It is suggestive therefore that the government should take proactive steps to address any loss of trust among patients and providers.

3.1.4 Trauma and the Psychosocial Health of Health workers

The violence meted on health workers and their relatives, as well as the experiences of having to treat or encounter victims of violence on a daily basis, reportedly traumatized the caregivers to the extent that they too, needed to be cared for. One health worker reported that even after all the messages of healing and reconciliation that were being preached from various quarters, encountering victims of the violence on a daily basis was a constantly disturbing reminder of what had happened. A second health worker narrated how daily experiences of the aftermath of the violence while working in the hospital wards affected her psychologically.

Box 5: Psychosocial needs of health workers

<table>
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<tr>
<th>...But what was even worse, we were threatened by the mob. They wanted to burn the facility down and lynch us. We were accused of trying to save members of certain communities by treating them instead of letting them die or even poisoning them. (Resp 4, Nairobi)</th>
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<tbody>
<tr>
<td>. . .You see just walking around and sitting down and just hearing bad news, and more bad news the whole day really put me down. There’s a weekend I couldn’t even just get out of bed. I realized I was really overwhelmed.(Resp 2 Eldoret)</td>
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The quotes in Box 5 are from health workers who were expected to treat and heal the rest of the population who sought care from them. However, those voices clearly suggest that health
workers were equally vulnerable, and whose needs for psychosocial support seem to have been forgotten during the conflict.

The fact that some counseling and psychosocial support were later provided on an ad hoc basis suggest that the welfare of health workers was not initially seen as a necessary component of the emergency response. Some health facilities actually reported that when the counseling and other psychosocial support for their employees was initiated, there was no official policy from the MoH to support such measures. In essence, these challenges point to a general absence of workplace support mechanisms to promote the welfare of health workers. By leaving the health workers to navigate the insecurity and the transport crisis that followed the PEV on one hand and the ad hoc manner in which cases of mistrust and discrimination were handled on the other, shows the extent to which the health system was unprepared to deliver equitable and high quality services. However, it should be emphasized that the above challenges were not directly caused by the PEV, rather, they are an indication of the general weaknesses in the health care systems that existed before the violence, and continues to date.

3.2 The effect of PEV on the Preparedness of the Health Care System to Deliver Services during Conflict Situations

3.2.1 Dislocation of the Continuum of Care

The combined effects of massive displacement of people, including health workers, had a major impact on access to and delivery of health care services. Freedom of movement was the most important determinant of access to care among people who were confined to displacement camps. Under these circumstances, proximity to a health care facility or availability of medical supplies did not guarantee access to health care services. In most cases, the only option was to organize mobile health facilities within the IDP camps. However, these temporal measures faced several challenges including staff shortages, ethnic animosity and displacement of patients. Availability of health workers and the ability of patients to physically access health facilities are essential for the proper functioning of the health care system.

The disruption of the continuum of care is further illustrated by what happened to patients who were on HIV & AIDS and TB treatment. In most cases, interviewees indicated that although there were no shortages in ARVs, patients missed their drug supplies and periodic assessment and monitoring for an extended period during the PEV due to loss of contacts. While ARVs were later delivered through mobile units in IDP camps and home visits by health workers, it was also reported that some patients especially those in camps were reluctant to take their medications openly due to the stigma associated with HIV & AIDS and TB. They were
concerned that taking ARVs in the full glare of other people in the camp was tantamount to declaring that they were HIV positive.

**Box 6: HIV & AIDS Patients and Dislocation of the Continuum of Care**

...Across the region, clinics shut down. Health workers stopped visiting rural homes and clinicians, who remained, began treating the wounds of conflict victims. But often the victims and their healers came from opposite sides of the ethnic divide.

(Resp 1, Eldoret)

...We were fully stocked in so many things. It was fully stocked in ARVs for two months in all our clinics and fully stocked for food. We work with the World Food Program and we had all the food there but we could not reach the people concerned.... (Resp1, Eldoret)

...In some areas where patients were unable to get their drugs at clinics, clinic personnel attempted to find them. That caused other problems. When we visited them in their homes, taking medicine to their homes, some would run away because of stigma-related issues... (Resp 1, Eldoret)

...Those patients on ARVs who remained behind were not disrupted in their regiment of treatment apart from those who were displaced by the clashes and had to move to other areas. We do not have the capacity of making follow-ups to our patients. We only attended to or served those who came to the clinic. (Resp 5, Nairobi)

...We have a supply chain that guarantees commodities are delivered in three months. So we did not have any problem with anti-retroviral drugs. The problem was that the patients could not travel from the village to the health facility to have their supplies What do you do? (Resp 4, Nairobi)

...You see, people left their villages. They were somewhere and we did not know where they were and whether they had enough drugs to maintain their treatment. So it was a very intensive (Resp 6, Nairobi)

While the quotes in Box 6 above largely refer to the dislocation of care for the HIV & AIDS patients, these challenges are true for most other health care services since most curative services are accessed from a fixed point under normal circumstances. It is only on few occasions where curative health services are actually taken to the patients. Therefore, displacement of people from their homes meant their ability to access healthcare facilities was greatly constrained. Inevitably, provision of health services is fundamentally premised on physical access (patients accessing health care facilities at a fixed point), with options for pick-up and outreach. Kenya’s health care
system is however not able to deliver services outside the health facilities even under normal circumstances.

The failure of health facilities to take services to where patients were concentrated, the inability of the patients to venture out of the camps and the insecurity posed even to those not living in camps meant that access to health care services was grossly undermined. The lack of capacity by health facilities to follow up with patients demonstrates again how pre-existing system wide weaknesses can compromise the ability to respond to the health care needs of the population during the emergencies. Such weakness must be addressed for the health care system to be able to provide accessible, acceptable and quality health care services at all times.

In addition, other forms of the PEV, such as the increase in Sexual and Gender Based Violence, made explicit the absence of skills and lack of capacity among health workers to offer certain critical health services. Some health care managers reported that some victims of SGBV were not promptly treated for a variety of reasons. First, most cases of rape and sodomy were not reported due to the stigma associated with them. Secondly, although PEP was provided within several health care facilities for those who managed to report, some health care workers were not well prepared to handle the treatment procedures due to lack of psychosocial and counseling skills. Psychosocial care and support are critical components for effective clinical management of SGBV because such cases are often accompanied by post traumatic stress disorder (PTSD). It should also be noted that most cases of SGBV took place in the rural areas where the community health workers (CHWs) are the first point of contact with the victims. In such circumstances, the CHW who are not trained to handle such cases could not provide effective care.

3.2.2 Disruption of Logistics and the Supply Chain

The collapse of the transport system was blamed for the failure to coordinate and deliver drug supplies from the central stores in Nairobi to the affected areas. The uprooting of sections of the railway line that serves Nyanza, Western and Rift valley cut-off transport between these regions and Nairobi. At the same time, the main highways that connect these regions with Nairobi were equally rendered impassable. Most of the people interviewed from both the government and mission sector felt that, to some extent, the health care system showed some elements of preparedness to deal with emergencies. It was reported that most health facilities had enough stocks to cope with the situation for at least two weeks, but shortages of drugs and other medical supplies started having a major impact after the transport network was thrown into disarray. Most shortages were mainly related to surgical and other materials for wound dressing as opposed to other drugs. Most facilities also reported that apart from offering services to the victims of the violence, demand for other services drastically reduced during that period.
Apart from drug supplies, it was reported that in most cases the health facilities were equipped to rapidly respond to casualties as they were brought to the health facilities. This was attributed to lessons learnt after the Nairobi bomb blast of 1998. However, this is the farthest that this preparedness seems to have gone, since broader challenges emerged at a later point that severed the emergency response. A key characteristic of the current public sector medical supply chain is that the periphery is served from a centralized point through the Kenya Medical Supplies Agency (KEMSA). However, the ability of KEMSA to serve the periphery is not only dependent on the amount of stocks it can deliver, but also the proper functioning of other systems, such as security and transport infrastructure.

The PEV emergency response involved many players, chief among them security agents, health personnel, humanitarian agencies and others. In the absence of a well functioning central coordinating unit, marshalling these players into unified response was not only difficult, but also time consuming. This is evidenced by the number of disaster coordinating committees established in order to restore order and focus the activities of the main actors involved.

In addition, the role of non-state actors in the emergency response was not well articulated and documented; the focus was mainly on the gaps and challenges highlighted at that moment. As a result, such responses were incomplete and often led to losses in efficiency. There have been concerns that most of the non-government players only focused on the delivery of humanitarian assistance, as opposed to joining the health care system in providing comprehensive care. The PEV also highlighted weaknesses in the coordination of health interventions at the provincial and district level which in essence, point to the failure of the government to protect, promote and fulfill the right to health.

3.3 Conclusion
The effects of PEV on health workers in particular, and on the delivery of health care services in general, suggest that the health care system in Kenya was not adequately prepared to provide accessible, acceptable and quality health care services, especially during a conflict emergency situation. First, health workers are an essential component of any plan that is aimed at bolstering the provision and utilization of health care services. However, the centrality of health workers to the proper functioning of the health system was undermined by the PEV in a number of ways, including staff shortages and heavy workloads that were a common experience in most facilities in Nyanza, Eldoret and some parts of Nairobi. This was a result of displacement, insecurity and the transport crisis described above. In addition, the PEV introduced a serious set-back in terms of the patient-provider relationship and the collegiality among health workers, which together have a potential to affect negatively the delivery of health services.
Second, the PEV brought to the fore several pre-existing weaknesses within the health care system that negatively affect the delivery of health services. For instance, on one hand health workers lacked skills to handle challenges related to the psychosocial needs of PEV victims, especially those suffering from SGBV, and lacked the skills to handle emergency trauma management on the other hand. Under such circumstances, health care workers saw the burden of care but felt incapable to deliver the care as required. In addition, the fact that no plans had been put in place to respond to the psychosocial needs of health workers during the conflict period is quite revealing of the general lack of workplace support mechanisms for health workers. The failure of the health care system to have a recognized department to deal with psychosocial and trauma counseling for the health workforce, for instance, is also an indicator of the inadequate attention paid to the welfare of health workers.

Third, the proliferation of actors in the provision of critical services, such as psychosocial and trauma counseling, raises another set of concerns regarding the preparedness of the health care system to deliver services under emergency situations. Psychosocial and trauma counseling services should be part a broader health systems response to emergency conflict situations. The failure by the MoH to offer these services provided an opportunity for other service providers to fill the existing gap. However, the services provided differred in quality, content and manner of delivery. This raises a fundamental issue regarding the standard and quality of counseling services.

The absence of a policy framework that seeks to standardize the content, delivery and the qualification of counseling practitioners might predispose trauma victims to exploitation by incompetent service providers. Indeed, this is an indication of how the government is failing in its obligation of providing high quality services. Again, this failure was not occasioned by the PEV but is a weakness that existed and continues to persist in Kenya’s health care system.

Although the configuration of the KEPH under the MoH strategic plan mainly envisages the delivery of health care services under normal circumstances, it is important to realize that the need for health care services does not stop with the end of periods of normalcy, but escalates with crises. The MoH strategic plan therefore needs to rethink its capability in terms of what would make the noble goals under KEPH attainable in both “normal” and emergency conflict situations. It is surprising that most respondents, including senior MoH officials and those from the mission sector, reported that the health care system was well prepared to provide health services in the event of an emergency. However, these sentiments differed sharply with those of health care managers on the ground, who said the system was largely ill-prepared.
A key lesson that makes explicit the lack of preparedness is the inflexibility and immobility of the health services with regard to taking services to the consumers. The loss of follow-up and the inability of the communities hosting the IDPs to access health care services attest to this. However, importantly, the disagreement over whether the system was prepared suggests the need to build a consensus on how to assess the preparedness of the various actors comprising the health care system to deliver equitable, accessible and quality health care services under such circumstances. Such consensus is a necessary first step towards innovation in the health care system to promote access to health care services.

The fact that the private and mission sectors were able to mobilize resources to respond fairly swiftly in certain areas should not be equated with preparedness of the health care system. On the contrary, the failure of health workers to deliver services as described elsewhere in this report and the broader dislocation of health consumers and the providers was a huge obstacle to access and use of health services.

Overall, there is limited learning within the system considering that the country had experienced nearly similar emergencies before in 1992 (e.g., Maela camp), 1997 (e.g., Likoni clashes), and 1998 (US Embassy bomb blast). Whereas previous ethnic clashes were of a lesser scale and magnitude compared to the one of 2008, they have many similarities. Thus, there is no excuse for the system to remain always reactive when it comes to the provision of health services during emergency situations. The snapshots provided by this assessment in general, and the experiences of what happened with regard to provision of both preventive and curative health services in particular, is a clear indicator of this lack of readiness.

Although most of the sentiments regarding the preparedness of the system seem to be based on whether there were enough drugs and medical supplies at the facility level, there is need to emphasize that adequate medical supplies alone cannot guarantee access to and utilization of health services. Other efforts such as equipping health workers with the requisite knowledge, skills and psychosocial support to tackle emerging health issues during emergency situations, establishment of alternative care sites, and provision of security for critical staff during emergencies are equally important.

3.4 **Recommendations and Suggested Areas for Advocacy**

3.4.1 **Specific recommendations for health workforce advocacy**

The assessment of the effects of the PEV on human resources and the ability of the health system to deliver equitable and quality health services has demonstrated the critical role that health
workers play in linking up factors such as infrastructure, financing and medical supplies (including drugs and equipment) and promoting access to health services.

The quality, acceptability, availability, and accessibility of services provided during the PEV period were shaped and influenced by the availability, competence and the motivation of health workers. However, it should be noted that some of the effects of the PEV on health workers, such as mistrust between patients and providers, the failure to provide psychosocial and trauma counseling to health workers and the heavy workloads were not necessarily caused by the violence, but rather stemmed from already existing and continuing neglect of the interests of the health workers at the broader system level. Enhancing the preparedness of the system to deliver health care services will require re-orientation of the thinking, design and the implementation of strategies that address the needs of health workers as critical pillars in the health system.

In order to address this neglect, three key areas are recommended for advocacy. First, there is need for the development and implementation of workplace support mechanisms addressing the welfare of health workers. Workplace support mechanisms are important for ensuring that employees feel comfortable and thus able to deliver the best level of care possible. However, issues such as discrimination or animosities between workers arising from ethnic origins curtail the ability of organizations to create suitable environments for both health workers and patients seeking care.

In terms of care for the health worker, neither government policies nor practice encourage appreciation and care for the health worker. While they are a critical component of health service delivery, the level of attention and resources allocated to care for workers is minimal. There have been strikes and other demonstrations of displeasure such as incivility, absenteeism and the like that hint at serious shortcomings at the workplace, but to date, have not been addressed.

Second, health workers have a duty and obligation to promote the health rights based approach to health service provision at their places of work. While KEPH has reformulated health service provision to accommodate the rights based approach to health, the PEV clearly showed that it is lacking implementation at the health worker level. An appreciation of this approach would therefore entail health workers knowing how to offer services that meet the standards of the rights based approach and do this without fear of discrimination or violence. To address this shortcoming, there is need for the MoH to clearly commit itself to developing and implementing programmes to re-train health workers on the rights based approach to health. Also, the government and partners should conduct public education on the meaning of the rights based approach and what it entails for both health workers and patients.
Third, there is need to build the capacity of health workers to handle concerns related to SGBV health needs. The handling of complaints related to SGBV during the PEV period shows the deplorable state of services delivered to people who suffered that form of violence. Proper management of SGBV requires a combination of psychosocial support with clinical treatment. However, it is clear that the lack of skills among health workers to offer psychosocial support compromises the clinical management of SGBV. Most health workers felt inadequately prepared to deal with the psychosocial component of treatment. Handling of SGBV issues is further complicated by the fact that, should the patient decide to get legal redress, the onus is on the health worker to accurately record and safely keep the record of the occurrence, as well as produce this evidence in court.

It should also be recognized that most of the SGBV complaints take place at the community level, where CHWs are ill-prepared to deal with such cases. This would suggest the need for a system wide thinking on a programme that builds the skills of health workers to deal with SGBV complaints. There is thus need to advocate for the training of health workers to offer psychosocial support, and/or create in each hospital focal points to which these cases can be referred for further support and follow up. This is in addition to empowering CHWs to identify and appropriately refer patients as they work in the community.

The government should educate health workers on the procedures of collecting evidence on SGBV cases to ensure that legal requirements are understood and applied to reduce the possibility of offenders being freed on technicalities. This should be tied with development of a synchronized system between hospitals, counseling services, the police and the judicial system to follow up cases of SGBV to their logical conclusion. Also, a media campaign should be established to create awareness on the severity of SGBV among the population as well as authorities that are tasked with the responsibility to address the issues such as the police, judiciary and the health system.

3.4.2 Specific recommendations for the health systems advocacy

In addition, it is apparent that the lack of access to health care services due to the dislocation of the continuum of care was a key challenge during the PEV period. In this case, efforts to improve the preparedness of the health system to deliver accessible, acceptable and quality health care services both in crisis and non crisis situations should critically engage with those factors that promote all forms of access to care. We draw four system level recommendations that can be explored for advocacy.

First, there is need to push the government to implement and prioritize recruitment and improved distribution of health workers as the first step towards promoting the right to health in Kenya.
Although the MoH has identified this as a key challenge facing the implementation of the KEPH strategy, further advocacy is required so that policies that impede recruitment of health workers are addressed. These include the lack of control over the number of health workers that the MoH can recruit, (considering that issues are decided by the directorate of personnel management,) the need to lift the embargo on recruitment of new staff outside the vertical programmes and the disparities in the distribution of the health workers, especially in rural and isolated areas.

Failure to address these system wide bottlenecks will not only compromise the ability to address the HRH issues, but will also make it difficult to hold the health system accountable for not fulfilling its obligation to promote the enjoyment of the right to health. Additionally, there is need to rethink the implementation of the community strategy that is meant to link the continuum of care at the community with other levels as envisaged under the KEPH. While the argument is not the CHWs would have filled the vacuum left by the displacement of other health workers, it is apparent that the CHWs would have been instrumental in ameliorating the relations between the care givers and the communities by bringing to the fore common health issues affecting the host communities.

Second, this report has clearly brought out the challenges experienced by health workers with regard to provision of psychosocial and trauma counseling services. The vacuum created by the failure by the MoH to provide psychosocial and trauma counseling services most likely led to the provision of counseling services whose quality is not only questionable, but unacceptable. The main problem seems to be the lack of a policy direction to guide the organisation of the services offered, including standardization of counseling training and quality assurance. There is also the need to advocate for the institutionalization of a psychosocial health unit within the operational plan of the MoH. Institutionalizing psychosocial health will help the MoH to acknowledge the importance of trauma-focused treatment, as well as adopt a system wide approach to responding to psychosocial health needs as opposed to the one-off counseling that is currently being offered. While there is every need to promote a conceptual distinction between psychosocial and mental health, care should be taken to ensure that the former is not established as a vertical programme to the existing mental health department.

Third, HERAF may consider undertaking a sensitization and public awareness campaign on the need to respect and protect health workers under all circumstances, and to recognize the critical and essential nature of the service they provide to all people, even under conditions that threaten their lives. Several approaches may be used for this, including mounting silent campaigns through posters and other materials in health facilities, especially in the areas that were affected by the violence.
Fourth, harmonizing and synchronizing the various strategies that seek to promote the right to health is an essential step in promoting the preparedness of the system to deliver health services by the government, non-state actors and other stakeholders. There is an urgent need to establish consensus on the lack of preparedness to respond to health care provision during emergency situations. This consensus should make explicit the centrality of access to health care services as a key determinant of preparedness, as opposed to the current flawed thinking that equates it to availability of drugs and medical supplies. Developing an appropriate Capability Assessment for Readiness (CAR) tool for Kenya may be considered a first step towards establishing this consensus, and provide some benchmark data for a broader framework to inform the development of strategies that promote, protect and fulfill the right to health. A simple CAR tool can be used by all actors within the health care system to evaluate their readiness to deliver services as envisaged under KEPH among others. Apart from helping the health system to convert from normal to surge capacities in case of another emergency, results from such a tool should provide a uniform guidance to stakeholders in the health system on what critical factors should be addressed in order to promote equitable access to health care services in Kenya.

Implementation of the above recommendations will therefore require a holistic system of monitoring the degree to which the government respects its obligations to promote, protect and fulfill the right to health by evaluating the availability, accessibility, acceptability and quality of health care service design and delivery. This will however require that health policy decisions and programming be supported by evidence generated using a right-based framework of analysis.
Endnotes

i Although Toole and Waldman (1997), Burkle jr (1999), Meek et al. (2000), Brennan and Nandy (2001) and Sondorp et al. (2001) discuss public health issues emerging from conflicts in Cambodia-Thailand in the late 1970s to the multiple crises in the Horn of Africa through the 1980s and 1990s, to northern Iraq, Bosnia, the former Soviet Union, and the Great Lakes of Africa that were not caused by election crises, we see characteristics exhibited by these situations as similar to those experienced during the post-election violence in Kenya. Waldman and Martone (1999) would refer to Kenya’s conflict as a ‘complex political emergency’ because it took place in the country, was to an extent rooted in political and social discord, has been of long duration, and, engendered forced displacement of relatively large populations. Victims of such violent conflicts are usually civilians whose social, economic, and cultural identities are targeted on the basis of their ethnicity with an increasing proportion of morbidity and mortality among them resulting from widespread human rights abuses.

ii The UNFPA report emphasizes the importance of determining primary duty bearers who will be responsible for providing health care services to the population. This marks a shift away from the needs based approach that relied on charity or good will of the duty bearers (i.e., Government or service providers) in service provision.

iii The recently published Waki Report states that over 900 SGBV cases were treated at the Nairobi Women’s hospital (a figure thought to be conservative). The Gender Based Violence Recovery Centre (GBVRC) at Kenyatta National Hospital served 184 cases between December 2007 and June 2008.

iv These figures are based on an assessment conducted by the National Nursing Association of Kenya in areas affected by the Post-Election Violence in the country.

v According to the Kenya Medical Association, insecurity was not only caused by organized gangs, but also the national security forces who invaded health facilities on several occasions. This is despite the fact that they were meant to protect health workers as they delivered health services. This was supported through a press release by the National Nurses Association of Kenya that was later reiterated by the International Council of Nurses (please visit: http://www.icn.ch/PR02_08.htm).

vi Some health care workers may have failed to turn up to work due to problems associated with lack of transport as opposed to displacement along ethnic grounds that occurred in most other places.